Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Carol G. Howell ugust 24, 2008 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 4c. County of Death Spital 1 Year | If Under 24 Hrs. 5. Social Security Number (In vrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Aq **Funeral** Days Hours 1 □ M 2 □ F Months Min 220-36-8779 65 Director 12-26-1942 MD Usual Residence of Decedent 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f shov Examiner must be notified at Yes 2□No Director N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1535 N. Gilmor Street 21217 S death 1 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🗓 No Specify Specify: Black Completed by 3 Widowed 4 □ Divorced traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) i and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) 12th grade N/A Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Richard Thomas ဥ Geraldine Street 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai once. 2204 Pinewood Avenue Apt B 3 Balto, MD 21214 Tiffany Howard-Grand Daughter

20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8-30-2008 King Memorial Pk 4 ☐ Donation 5 ☐ Other (Specify) RANDALLSTOWN, 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H (3 nambe Millar Avenue Balto, MD North 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated experts.) Due to (or as a consequence of Examiner The law requires that the death certificate be executed the burial-transit that initiated events resulting in death) Last attending physician and for use as the burlal-tran Due to (or as a consequence of): Box 68760. Physician/Medical as 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Vear 4☐Pregnant at time of death 5 Other (specify) ed by the a Records, P.O. 9 Unknown 9 Unknown signed by t d be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Completed peen s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Ves 2 No has this certificate 1□ Yes Division or Vital 25. Was case referred to medical examiner? funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 Tyes 2[] No 1 Inpatient 2 2 ER/Outpatient 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death. To the Funeral Director: After Certification: or Attending Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ 4 Homicide the Hospital 🛮 🖟 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Singh Rahulkumou

State Registrar 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06403 State of Maryland / Department of Health and Mental Hygiene Tracey Hutson 27502 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day August 21, 2008 1403 hrs Medical Examiner TRACEY LYNN HUTSON c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Harford Edgewood 2410 Romney Way 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or if Under 1 Year If Under 24Hrs. 6. Sex 7. Age (in yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Director Country) MARYLAND 218-84-5290 M 2 F 01 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 1 Yes 2 No TOPPA 28a-f show MI HARFORL must be notified at once. Director 10g. Citizen of What Country? 10f Zip Code 10e. Street and Numbe USA 21085 2410 ROAD ROMNEY Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 11. Marital Status Armed Forces? 1 Never Married 2 Yes 9 2 No Specify: WHITE specify. If Yes, Give Year Yes after at of Health and Mental Hygiene.

t: If item 27 is marked other than "natural", other traumatic event, the Medical Examiner. Widowed Divorced 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 hours a tent of Health and Mental Hygiene. ant: If item 27 is marked other than "natura 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 VETERINARY TECHNICIAN ANIMAL HEALTHCARE 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) CAROLYN ANN SPENCE - LOWERS HUTSON CHARLES MARION 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) CUEDR CREEK GLEN 90 ELK 2000 WD 31391 CAROLYN HUTSON 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) Burial 2 Cremation HANOUFR, MARTLAND portant: CIZEMMORY AULUST 26 2008 ARDS Other Specify Donation 5 22. Name and Address of Facility 21. Signature of Fune al Service Licensee COTTOMASTS THEOSTA GLOIP YM YMCHAH H 315 DO. CONNELLEY **4627** Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a Mixed drug (alprazolam, Oxycodone, Quetiapine) Immediate Cause (Final disease xaminer intoxication or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed Physician/Medical AMENDED 23a, 27, 28a-f, perME, G883 9/12/08 TT X UNPENDED physician the burial -Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Day Year attending p Live birth Fetal death past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 ✔ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available has been s 24a. Was an prior to completion of cause of autopsy performed? death? 2 No Yes 2 1 🗸 Yes certificate 26.Place of Death (Check only one) 25. Was case referred to medical or Attending Physician: Division of Vital Be examiner? Hospital: Other₄ Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 DOA After this ٩ 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27 Manner of Death Certification: 1 Natural Yes 2 X No unk Director: Pending hours after death. Fnd 8/21/08 Fnd 1:41 pm 2 Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) single family residence (four d) or Toyn, State) 2410 Romney Way 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide the Hospital To the Funeral Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 24 cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License numbe August 22, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Tasha Greenberg MD.

DHMH 17 Rev 1/2001 OCME 2006

Registrar

OCME

2008

32. Registrar's Signature

31. Date filed (Month, Day, Year

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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Z U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Vivian W. Ho lub 23, 2008 11:42PM M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** FutureCare Cherrywood Reisterstown Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 □ M 2 1 F 92 **Director** 334-16-1327 13,1916 Illinois Jan. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Example to motified at Director MD 1 ☐ Yes 2X No Baltimore Owings Mills 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 36 Garrison Ridge Court 21117 by Funeral USA 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian within 72 hours after 1 ∐Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: Specify: 3 ☑ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, It a Me Elementary/Secondary (0-12) College (1-4or 5+) Clerk Railroad 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၉ Grover Wertz Bernice Truitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David W. Evans Son 36 Garrison Ridge Court, Owings Mills, MD 21117 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 8/28/2008 Pine Crest Cemetery Mobile, Alabama 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 11824 Reisterstown Road Eline Funeral Home Reisterstown, MD 21136 ans in 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Metastatic Cunceral Known /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed A and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ sign be page 2 should Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performed' certificate 1 □ Yes 2 🗆 1No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ☐ No Certification: To 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 27. Man or of Death Natural After 28a. Date of Injury 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 5 Pending death. investigation 1 ☐ Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Ch

State

Registrar

Main 31. Date filed (Month, Day, Year) AUG 2

30. Name and address of person

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29b. Signature

Reisterstown 32. Resistrar's Signature

cause of death (Item 23a) (Type, Print)

and manner stated.

DHMH 17 Rev 1/2001

29c. License number

1005333

29d. Date signed (Month, Day, Year)

		For		artment of Health and Me	•		27504
		State Registrar 1. Decedent's Name (First, Middle, Last		ertificate of Death	Rag. 2, Date of Death	No.	3. Time of Death
Physic /Med		ELVA,	HUFF		Ausus+	Day 20 Year	8 1:35 PM
Exam	ner	4a. Facility Name (If not institution, give 2829 LODGE FAC		4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Funera Directo			7. Age (In yrs. last birthday ☐ M 2☐ F 92 Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth Month Day, Ye 8-11-19	9. Bint MAI	place (State or Foreig Info:) XYLAND
/land		Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or L	ocation			10d. Inside City Limits
Man a-fah	tor	MD. N/A	BALTI	MORE			1 Yes 2 No
or 28	Olre	10e. Street and Number		10f. Zip Code	10g.	Citizen of What Cor	untry?
ath w	ral	2829 LODGE FARM		21219		USA	
Daltimore, IMaryland ZIZI3-UU30 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f ahow any injury or other treumatic event, the Mc.dical Evant learmante invilled at once.	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married 33 Widowed 4 □ Divorced	1 □ Yes 24∑ No If Yes, Give	Was Decedent of Hispanic Origin? (Spec If Yes, specify Cuban, Mexican, Puerto Ri 1 Yes 2 No Specify:	ity Yes or No- ican, etc.)	14. Race - Amer Black, White Specify: RT	
2 hour	edt	15. Decedent's Edu	Year or Dates:	edent's Usual Occupation	16h	. Kind of Business/l	
Z1Z15-UU36 ad within 72 hours aff gjene. er than "natural", or t, the Wedfool Evani	Completed	(Specify only highest grad	le completed) (Giv.	e kind of work done during most of working DO NOT use retired)	, , ,		
K Pienth	Con	Elementary/Secondary (0-12)	College (1-4or 5+) -2- NUI	RSE		HEALTHCA	ARE
Maryland ZIZIS nd 2 should be filed within lith and Mental Hygiene. 27 Is marked other than "	To Be	17. Father's Name (First, Middle, Last) WILLIAM CARTER		18. Mother's Name (BESSIE		den Sumame)	
Alary 2 sho and i 1s ma		19a. Informant's Name/Relationship (T)		ing Address (Street and Number or Rural i	Route Number, Ci	ty or Town, State, Z	p Code)
T, III		PATTY WILSON (G	RANDDAUGHTER) 414	9 DAY LILY DR. OWIN		_	
Dallillore, IN permit. Pages 1 and Department of Heath Important: If item 27 any injury or other tr once.	1	20a. Method of Disposition 1 ABurial 2 Cremation 3 DF	Removal from State	osition (Name of properties) E NATIONAL 8-25-2		Location - City or 1	
Dallinoie; Dermit. Pages 1 ar Department of Hear mportant: if item any injury or othe		'4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Europe Service (Cen	9	Name and Address of Facility PIIII		ALTIMORE,	
Dermi Depa Impo any ii		Vante		.721-27 N. MONROE ST			
Pnysician		Immedia e vause (Final	ications that caused the death. Do not en ne cause on each line. Advanced D		respiratory arrest,		Approximate Interval Between Onset and Death
/Medical Examiner		disease V condition resulting in death)	Due to (or as a consequence of):	D-11C-1 10-1			Syears
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g physician and as the burial-transit	=	resulting in death) Last	Due to (or as a consequence of):				
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taw requires that the death certificate as been signed by the attending physical should be detached for use as the	Physician/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □Unknown		□Ectopic pregnancy □ Other (specify)		23d. Date of delin Month	<i>re</i> ry Day Year
quires that to signed by	by	Part II. Other significant conditions con Chrosc Obstruct	ntributing to death but not resulting in the three Pulmonory	underlying cause given in Part I.	23e. Did tobacc	co use contribute to	
he h	ompleted		,		24a. Was an autopsy performed	prior to c death?	opsy findings available ompletion of cause of
	0	25. Was case referred to medical		26, Place of Death (No 1 ☐ Yes	2LJ No
Physician: this certificant	To B	eyaminer?	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other		6 □Other (Spec	ify)
	atlon:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year) 28b. Time of Injury		d. Describe how in		
P in the second	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office 28	f. Location (Street City or Town, St	and Number or Rui ate)	ral Route Number,
To the Hospital or within 24 hours after To the Funeral Direction Completely filled in	edical C	29a. Certifier 1 Certifying Physical Check only one) 1 Medical Examination	sician: To the best of my knowledge, deal ner: On the basis of examination and/or in and manner stated.	th occurred at the time, date and place, an exestigation, in my opinion, death occurred	d due to the cause at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
ro the vithin round to	Me	29b. Signature and title of certifier	1	29c. License number	29d.	Date signed (Month	, Day, Year)

State

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month Bay, Year) AUG 2 6 2008

29b. Signature and title of certifier

32 Registrar's Signature

2, majiel in D

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cathleen F. Masill, 4940 Eastern Avenue, 18 altomore, MD 21224

August 20, 2008

29c. License number 566043

DHMH 17 Rev 1/2001

Registrar

			State of Maryland / Department of Health and N 1 - State Registrar Certificate of Death		giene _{Reg. No.} 20 (08 27505
	Dhysisi	.	Decedent's Name (First, Middle, Last)	2. Date of Dea	ath	3. Time of Death
+	Physici /Medio			Aug.	24, 20	
	Examir	er	4a. Facility Name (If not institution, give street and number) Chesapeake Hospice 4b. City, Town, or Location of Death Linthicum		4c. County of I	Death
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. On 1 1 0 0 1 1 M 2 F Yrs. On 1 1 0 0 1 M 2 F Yrs.	8. Date of Birl (Month, Da	th 9.	Birthplace (State or Foreign Country)
	Director		219-40-1100	9/09/1	942	MD
	yland now		10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	a-fsh	ctor	MD Baltimore Baltimore			17 Yes 2 □ No
	th with the 23a or 28 ust be no	ral Director	10e. Street and Number 1003 Herdon Ct. 10f. Zip Code 21225		10g. Citizen of Wha	t Country?
5-0036	thin 72 hours after death with the Maryland e. an "natural", or items 23a or 28a-f show Madical Examinar must be notified at	by Funeral	11. Marital Status 1 Never Married 2 Married 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never in U.S. Armed Forces? 1 Never in U.S. If Yes, specify Cuban, Mexican, Puerto 1 Never in U.S. Armed Forces? 1 Never in U.S. If Yes, specify Cuban, Mexican, Puerto 1 Never in U.S. If Yes, specify Cuban, Mexican, Puerto 1 Never in U.S. If Yes, specify Cuban, Mexican, Puerto 1 Never in U.S. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.)		American Indian, Vhite, etc. White
ς Θ	72 hor	eted	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of work	ina	16b. Kind of Busin	ess/Industry
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7 0	be filed w ntal Hygie ed other t event, III			(First Middle	Own Hor	116
la E	be od o	To Be	Walter Evans Helen			
a Z	d 2 should be th and Menta 7 is marked traumatic ev		19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Run	al Route Numbe	er, City or Town, Sta	ite, Zip Code)
 (v)			Thomas P. Giusto/Son-in-law 8203 Royal Star C 20a. Method of Disposition (Name of Disposition Disposition (Name of Disposition Dispositio	t. Pas	adena MI	
D F	ages ent of nt: If its y or o		1 Burial 2 Cremation 3 Removal from State	. 26,	Beltsvi	
saitimore	permit. Pages 1 an Department of Heal Important: If Item 2 any injury or other once.		21. Signature of Funeral Service Licensee 22. Name and Address of Facility CAF	A/Step	hen D.L	ohrmann P.A.
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac			MD, 21286 Approximate
	Physician /Medical Examiner		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):		13 Lese	Interval Between Onset and Death
14	cuted d	Examiner	Sequentially list conditions, if any, earning to him collections are cause. Enter Underlying Cause (Disease or injury that initiated events			
00/00	cate be executed physician and the burial-transit	cal Exa	resulting in death) Last Due to (or as a consequence of):			
0	rtificat ng phy as th	Medical	IF FEMALE:			
.O. DOX	To the Propriat or Attending Prysician: In law requires that the death. Within 24 hours affect death. The Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	23b. Was decedent pregnant in the past 12 months? 1		23d. Date o Month	f delivery Day Year
cords, r	w requires that the de been signed by the should be detached	Completed by Pr	Part II. Other significant conditions contributing to death but not resulting the underlying cause given in Part I.		•	te to the cause of death?
၁ ၁	e law rec has bee je 2 shou	plete		24a. Was		e autopsy findings available
ב ק	cate h	Com		autop perfor 1 □ Yes	rmed? deat	r to completion of cause of h? Yes 2DNo
7	sician certifi rector	Be	25. Was case referred to medical examiner? Hospital: Hospital: Other: O			esageale
5 i	g Physer this eral di	2	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at		dence 6 Other (specify) Hespira House
5 :	ath. r: Aft	atio	19≝ Natural 5 Pending (Month, Ďay, Year) Injury Work? 2 Accident investigation M 1 Yes 2 No			
	I or Atter de after de Directo	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S City or Tow		r Rural Route Number,
	to the hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical C	29a. Certifler (Check only one) Certifor (Check only one) Check only one)	and due to the red at the time,	cause(s) and mann date and place, and	er as stated. due to the cause(s)
;	within To the compl	Me	29b. Signature and title of certifier 29c License number	3	29d. Date signed (M	fonth, Day, Year)
			() < 5 \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	/	Hugust	25,2004
	3		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)) 50 G	Jen Buri	s. r.l. 21067
	Stat Registra		31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature		1101-	
			Mills V. 1 COOO Programmed and the second			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death **Physician** ackson Haust 2008 /Medical 4b. City, Town or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore altimove Mally 05 If Under If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day May 24 5. Social Security Number Funeral Months Days 1 M 2 F unk. Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 1∩a State 10h. County 10c. City, Town or Location 10d. Inside Lity Limits 1 Yes 2 No **Funeral Director** Marylan 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubap, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Black If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired). Elementary/Secondary (0-12) College (1-4or 5+) Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be unknown Department of Health and Men Important: If item 27 is marke any injury or other traumatic ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Uctavian Jackson - son talou 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20c. Location - City or Town. State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) LIVEV Fallure /Medical Due to (or as a consequence of): **Examiner** White C and Alcohol Use if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending house and Division of Vital Records, P.O. Box 68760, ${\mathcal K}$ Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) JYes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>ک</u> 2 No 3 Probably 4 Unknown 1 🗌 Yes completely filled in by the funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 🔀 Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Rebecca

31. Date filed (Month, Day, Year)

Powell

S.

arcone

32. Registrar's Signature

Street

ORIGINAL

Balhmore MD 21230

DHMH 17 Rev 1/2001

			For State Registrar	State of Ma		epartment of l Certificate of			giene Reg. No.	$Z \coprod Z$	27507
	Physici	an	1. Decedent's Name (First, Middle, L.	ast)				2. Date of De Month	ath Day	Year	3. Time of Death
	/Media		SHIRLEY V. KI					Aucus		2008	
	Examir	er	4a. Facility Name (If not institution, gi UNION MEMORIA				or Location of Death	1	4c.	County of Deat N/A	h
	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last birtho	tay) If Under 1 Year	If Under 24 Hrs.	8. Date of Bir (Month, Da	th	9. Birt	hplace (State or Foreign
	Director		219-22-6812	1□M 2፟፟ M 2 M 5	80 Yrs	s. Months Days	Hours Min.	3-28-1	928		RYLAND
pue	*		Usual Residence of Decedent 10a. State 10b. County		10c, City, Town o	r Location					10d. Inside City Limits
Varvii Varvii	fsho	ō	MD. N/A		BALTI						1 □XYes 2 □ No
the	r 28a	Director	10e. Street and Number		DALIL	10f. Zip Code			10g. Citiz	zen of What Co	untry?
th wit	23a o	alD	3015 CHELSEA	TERRACE		2121	6		1	USA	
er dea	tems for m	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?		13. Was Decedent of I	lispanic Origin? (S an, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 1	14. Race - Ame Black, White	
S affe	", or i	by F	1 ☐ Never Married 2 ☐ Married 3 🖾 Widowed 4 ☐ Divorced	1 □Yes 2 No If Yes, Give Year or Dates:		1 □Yes 2X No	Specify:			Specify: BL	ACK
G ZIZI3-UU30 filed within 72 hours after death with the Maryland	atura	ted	15. Decedent's B	ducation	16a. De	ecedent's Usual Occu	pation		16b. Kir	nd of Business/	Industry
7 Int	an "n	Completed	(Specify only highest gr Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	- //	live kind of work done fe. DO NOT use retire	during most of wor d)	king			
ed wi	ygien ner th	S	-12-	-3-		LABORER				RIETTA	MARTIN
Pe ⊞	ntal H ed otl	Be	17. Father's Name (First, Middle, Las JESSE BAILEY	1)			18. Mother's Nan	ne (First, Middle) CURTIS	Maiden S	Surname)	
T V	mark matic	မ	19a. Informant's Name/Relationship	(Type Print)	19h M	ailing Address (Street	1		er City or	Town State	Zin Code)
19 S	alth ar 27 is r trau			MS (DAUGHTEI	1	800 S. ZEN			. ,		in Gode)
e ta	of Hei		20a. Method of Disposition		20b. Place of Di	sposition (Name of crematory or other pla	,	Date		cation - City or	Town, State
Page	ment ant: II ury o		4 ☐ Donation 5 ☐ Other (Speci		BALTIMO	RE NATIONA	L 8-29	-2008	BAL	TIMORE,	MARYLAND
Dall permit.	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Exprendent must be neithed at once.		21. Sig ature Funeral Service ice	ee JONATHAY	B. HIBNI	1721–27 N					, P.A. YLAND 21217
			23a. P. rt 1. Enter the disease, or con hoc or heart failure. List only	pplications that caused the	he death. Do not	enter the mode of dy	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between
् Pŀ	nysician		Imm Idiate Cause (Final dise ise of condition	SEPTIC	_						Onset and Death 2 weeks
	Medical xaminer		resulting hideath)	A	consequence of):						
		-	Sequentially list conditions,	b. Acute	SUPPLY CONFEQUENCE OF	ATTIVE CI	to LECYSI	7775			HTWOM
nted	d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	2 30 10 (0) 20 0	consequence on,						
icate be executed	physician and the burial-transit		resulting in death) Last	Due to (or as a	consequence of):						
ate b	hysici the bu	lical		d							
		/Mec	IF FEMALE:	22a If yes autoome of	f prognongy						
Physician: The law requires that the death certif	attending p for use as	Physician/Medical	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2 4 Pregnant at t	Fetal death	3 ☐ Ectopic pregnand 5 ☐ Other (specify) _	су		2	3d. Date of del Month	ivery Day Year
the d	by the tached	ysi	1 □Yes 2 ☑No 9 □ Unknown	9 Unknown	and of double	J D O BIET (Specify)					
s that	signed t	by PI	Part II. Other significant conditions	contributing to death but	not resulting in th	e underlying cause gi	en in Part I.	23e. Did t	obacco us	se contribute to	the cause of death?
equire	s been sig should b							1 🗆	Yes 2∑	2√No 3 □ Pr	robably 4 🗌 Unknown
N	as be	Completed						24a. Was		24b. Were au	itopsy findings available completion of cause of
: The	cate h	Con						perfo 1 ∐ Yes	rmed? 2 No	death?	2 □ No
y ILC	certificat irector, pa	Be	25. Was case referred to medical examiner?	Hospital:		Ott	26. Place of Dea				
Z A	er this eral dii	<u>1</u>	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient	t 2 ER/Outpa	Ment 3 DOA	4 🗀 Nuising n	ome 5 ☐ Resi 28d. Describe			cify)
ding 5	tth. : Afte e fune	Certification:	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day,	Year) Injui	ry Woi	k? Yes 2 □ No	200. 20001100	now injury	occurred	
Atte	er dea rector by th	tifica	3 ☐ Suicide 6 ☐ Could not be determined		y - At home, farm,	street, factory, office		28f. Location (Street and	l Number or Ru	ural Route Number,
<u>a</u>	rrs aft ral Di	Cer							,		
ne Hosp	within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical	29a. Certifier (Check only one) 1 Certifying Place Check only one)	hysician: To the best of miner: On the basis of e and manner state	examination and/o	eath occurred at the t or investigation, in my	me, date and place opinion, death occu	e, and due to the rred at the time,	cause(s) date and	and manner as place, and due	s stated. to the cause(s)
101	with Com	Ž	29b. Signature and title of certifier			29c. Licens	se number		29d. Date	e signed (Mont	h, Day, Year)
			1017K	\rightarrow	MD	ATZ	+38946		Anol	ust 21	, 2008
,	5		30. Name and address of person who	-		3 .	1	1.1			
	Stat	te	31. Date filed (Month, Day, Year)	LANNERY 32. Registrar	's Signature	MUION 1	remoria.	1 HOSE	ITM.	- , m	10.
	Registra		AUG 2 6	2008		Anach 1					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend 1 tem 4c per doc g882 8-27-08 vt.
State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Dav Month **Physician** 1 ane er Bert 12008 υ /Medical 4c. County of Deat 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Pardallstoun , Many the west Social Security Number 216-74-7567 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1⊠M 2□F Months Days Director 52 March 20, MD Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or Items 23a or 28a-f show Examiner must be notified at MD Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1030 East 33rd Street Apt. 417 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ₩Never Married 2 Married Baltimore, Maryland 21215-0036 Yes, Give 1 ☐ Yes 201 No Specify Black Completed by 3 Widowed 4 Divorced Year or Dates Item 27 Is marked other than "nature other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed withi Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event: the M. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Lane, Sr. Gladys Lane P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sylvia Lane 1030 East 33rd Street; Baltimore, Maryland 21218 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State NX Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Vet. Cem. 08/07/2008 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Wylie Funeral Home, P.A. 638 N. Gilmor Street; Baltimore, Maryland 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Due to (or all a consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) Physician: The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ate has been signed by the atterpage 2 should be detached for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No cate 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 50 DO061886 30. Name and address of person woomplete cause of death (Item 23a) (Type, Print) 31. Date fled (Month, Day, Year, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06396 State of Maryland / Department of Health and Mental Hygiene Jesse Leroy Malcom 27509 21118 1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) Jesee Leroy Malcolm, III 2. Date of Death 3. Time of Death Physician/ 0000 hrs August 18, 2008 Medical Examiner Jesse Leroy Malcolm, 4b. City, Town, or Location of Death c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore **Baltimore County** 240 S. Tionesta Road 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Foreign Months Days Hours Min Director 06/17/1960 Country) MD Yrs 218-80-9247 X M 2 F 48 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 No MD Baltimore 28a-f show must be notified at once. death with the Maryland Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 USA 2405 Tionesta Rd. 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Married 2 Married 2 X No Yes White 1 Yes 2 No Pages I and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. It ansit: If team 27 is marked other than "natural", or other traumafite event, the Medical Examiner. Specify: If Yes. Give Yea specify: 3 Divorced Widowed þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Flementary/Secondary (0-12) College (1-4 or 5+) MD Cup 21215-0036 Assembler 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Melvalene Virginia Eckert Jesse Lerov Malcolm Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 2405 Tionesta Rd. Apt. 2D Balti, MD21227 Melvalene Malcolm/Mother 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Aug 22, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Beltsville, MD portant: I Chesapeake Crem. permit., Page Department 2008 Donation 5 Other Specify: 22. Name and Address of Facility CAFA/Stephen D.Lohrmann P. 21. Fignature of Funeral Service Licensee Tu 8717 Green Pastures Dr. Balti MD. Approximate Interval 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line. /Medical Death Quetiapine intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical **#1perME,g8828 828/08 TT** 23a,27,28a-f,perME, g884 10/15/08 TT X UNPENDED **AMENDED** attending physician or use as the burial Box 68760. 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown g Unknown signed by the a be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. o ₽

Division of Vital Records, P.O. Box 68760,

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

Jo the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be deached for use as the build - transit

Completed

Be

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Certification:

Medical

29b. Signature and title of certifier

Theodore M. King, Jr., MD.

23e. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 ✔ Unknown 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Hospital: Other₄ Nursing Home 5 Residence 6 ✔ Other: Scene Inpatient 2 ER/Outpatient 3 DOA 1 V Yes 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Yes 2 X No unk Natural Pending Fnd 8/18/08 Fnd 2:00 2 Investigation Accident 28f. Location (Street and Number or Ryral Route Number, City or Town, State) 240 S. Tionesta Rd 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6 X Could not be Suicide house (Specify) Baltimore, MDHomicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 22, 2008

State Registrar

31. Date filed (Month, Day, Year) 32. Redistrar's Sign

30. Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien () Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) :30 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number ANNE DRUMBEL ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex 1 M 2 □ F 5. Social Security Number Days 253-20-4958 82 10/25/1925 LOUISIANA Usual Residence of Decedent 10d Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No MD ST. MARY'S LEONARDTOWN 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 20650 19381 DIZIVE SUNSET 12. Was Decedent Ever in U.S. Amed Forces? 1 M/ss 2 \(\text{DN}\) No If Yes, Give Year or Dates: 1943 ~ 1963 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 ☑ No Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) ELECTRONICS SPECIALIST ELECTRONICS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) EMMA DUTY JOHN MOURICE MYERS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19381 SUNSET DRIVE LEONDROTOWN, MD 20650 MILDRED P. MYFRS/WIFE 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State AUGUST 27, 2008 HANOURR, MD ardent crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
ARDENT CREMATION
7532 CONNECTO 21. Signature of Funeral Service Licensee DR. STEN, HANGUER, MB 2:076 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3□ DOA

Physician /Medical Examiner ed by the attending physicien and detached for use as the burial-transit The law requires that the death certificate be executed

Physician /Medical

Examiner

Funeral

Director

or 28a-f show

the Medical Exeminer must be notified at

"natural", or iteme 23a

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or item eny injury or other traumatic event, the Medical Exten

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

Hospital or Attending Physician:

within 24 hours after death. To the Funeral Director: A

illed in by

Medical

Director

Funeral

Be

Physician/Medical Examiner Š certificate has been signi rector, pege 2 should be Completed After this certification funeral director, Be Certification: To

examiner?	lo
27. Manner of Death	
1 Natural	5 Pending
	investig

5 Pending

Date of Injury (Month, Day Year) investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifie (Check only one)

3 Suicide

4 ☐ Homicide

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature, and tole

D65835

29d. Date signed (Month, Day, Year)

enter 900 BestgateRd#300 Annapolisil ed cause of death (Item 23a) (Type, Print) Annabolis Oncology

State Registrar

31. Date filed (Mor



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 8:00 A M **Physician** 2008 Mayonado trans /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Tal but 712 Wayside Avenue
5. Social Security Number 6. Sex taston Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. 212303607 April 22,1934 74 maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heatih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the "Marical Experiment and by marified at 28a-f show 1 □Yes 2 No Easton Director Talbot WD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 2160 712 Wayside Avenue Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 ☐Yes 2 Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) epartment Elementary/Secondary (0-12) College (1-4or 5+) Store Manager 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Evelyn White Mayonado 1110 19b. Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Easton MD21601 712 Wayside Joan Mayonado 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Hanover MD 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Anatorny Gifts Registry 8-26-08 4 Onation 5 ☐ Other (Specify) 22. Name and Address of Facility Anatomy Gifts Registry 21. Signature of Funeral Service Licensee ma1358 7522 Connelley Dr. Harrover, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine he attending physician and defor use as the burial-transit law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🔲 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) To the Hospital or Attending Physician: The law requires that the de within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the completely lilled in by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 □ Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signatule and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mary S. De hields, no Ste. MD. 101 Registrar's Signature 31. Date filed (Month, Day, Year) State

UHMH 17 Hev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

		for State Registrar	State of	Maryland / De	partment of Certificate of	Health and I Death	Mental Hygid Reg	ene 2 0 0 8	3 27512
Physic		Decedent's Name (First, Mic Edit	nund Bened	lict Maschin	isky, Sr.		2. Date of Death Month	g 21, 2008	3. Time of Death 8:50 AM
/Med Exam		4a. Facility Name (If not institu		ber)		or Location of Death		4c. County of Dea	ath Carroll
Funera Directo	_	5. Social Security Number 187-03-2543		7. Age (In yrs. last birthd 91 Yrs	Months Davs		8. Date of Birth (Month, Day, Nov 25	9. Bi 6, 1916	rthplace (State or Foreign Country) PA
Maryland f show	Į	Usual Residence of Decedent 10a. State 10b. Cour MD	Howard	10c. City, Town or	Location	Ellicott Ci	ty		10d. Inside City Limits 1 □Yes 250 No
with the far or 28a-	Funeral Director	10e. Street and Number 9394 Paulskirk D			10f. Zip Code	21042	100	g. Citizen of What C	Country?
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentall Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, in Modical Engineer must be notified at	d by Funer	11. Marital Status 1 Never Married 2 N	12. Was Deced	No des:	1 □ Yes 2 No	ban, Mexican, Puert	o Rican, etc.)	14. Race - Am Black, Wh Specify:	ite, etc.
iled within 72 h Hygiene. ther than "natu	Completed	15. Decec (Specify only hig Elementary/Secondary (0-12 12 17. Father's Name (First, Midd		(G	ecedent's Usual Occi live kind of work done le. DO NOT use retire	e during most of wor ed)	king		provement
should be find Mental H	To Be		Kasmir M		ailing Address (Stree		Ma	ıry Chickitis	Zin Code)
and 2 sh Health and m 27 is n		19a. Informant's Name/Relation Mary Ellen Evan		1	7443 North 7	9th Street Sc	ottsdale, AZ		
mit. Pages 1 partment of I portant: If ite		20a Method of Disposition Burial 2 Crematic 4 Donation 5 Other		tate	sposition (Name of crematory or other pla awn Memorial C	Sardens Au	g 25, 2008		sville, Maryland
permit. Departr Imports any inji	olice olice	21. Signature of Funer Servi	MULTINE	MOROB	3871 (Funeral Home Old Columbia I	Pike Ellicott Ci		Approximate Interval Between
hicate be executed transit as the burial-transit		23a. Part 1 Serfer the disease shock, or heart fallure. L Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to (c	or as a consequence of):	arten	dinfa	retur		Onset and Death
Physician: The law requires that the death certificatribines that the death certificate has been signed by the attending pfrail director, page 2 should be detached for use as the section of the control	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live bi	ome of pregnancy rth 2 Fetal death ant at time of death wn	3 ☐ Ectopic pregnar 5 ☐ Other (specify)			23d. Date of o	delivery Day Year
w requires that been signed by should be deta	þ	Part II. Other significant cond	ditions contributing to dea	ath but not resulting in th	ne underlying cause g	jiven in Part I.	23e. Did toba		to the cause of death? Probably 4 Unknown
ician: The law requir certificate has been si ector, page 2 should I	e Completed	25. Was case referred to med	ical			26 Place of Do	24a. Was an autopsy perform 1 □ Yes 2	prior t death 1 □ Y	
Attending Physician: The laver death. rector: After this certificate has by the funeral director, page 2	ertification: To B	examiner? 1 Yes 2 No 27. Manner of Death Natural 5 Per 2 Accident	Hospital: 1 □ Ir 28a. Date o ding estigation (Monti	patient 2 ER/Outpa f Injury n, Day, Year) 28b. Tim Inju	ne of 28c. Inj	ther: 4 \(\sum \) Nursing \(\text{P}\)	dome 5 ☐ Resider	nce 6 Other (S	pecify LIVING
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	O	4 ☐ Homicide deta	buildin	of Injury - At home, farm g, etc. <i>(Specify)</i>			City or Town,	, State)	Rural Route Number,
To the Hospital or within 24 hours after To the Funeral DII completely filled in	Medical		fying Physician: To the cal Examiner: On the ba and mann	sis of examination and/	or investigation, in my	y opinion, death occ	urred at the time, da	ite and place, and c	lue to the cause(s)
No it	Σ	29b. Signature and title of cert	aghs m	.5	29c. Lice	D35217		August	12,2008
5		Jackson, Day 31. Date filed (Month, Day, Ye	7/d. MD 11055 Li		arkway, Suite	209 Columbi		•	
Reais	tate strar	AUG 2	7 2008	Seven St.	Coast				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Year 50 PM Physician MATTISON August 2008 23 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Northwest Randallstown Baltimore Hospital If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Year) 1 ☑ M 2 □ F Months 214-66-6364 Director 1955 Maryland May Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location notified at 1 ☐Yes 2√ No Directo Carroll Maryland Finksburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number ed other than "natural", or Items 23a or event, the Medical Examiner must See 21048 USA Old Westminster Pike Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☑ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: ρ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If item 27 is marked other the any Injury or other traumatic event, Intel once. Drywall Finisher Construction 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Elizabeth Carrick ည Charles Mattison 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joyce Almond Sister 1031 Kinsbury Road Reisterstown, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/25/08 Hampstead, Maryland Carroll Crem. Serv 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Ze. 21136 ELINE FUNERAL HOME Reisterstwon, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) **Examiner** neumonia Sequentially list conditions, if any, leading to immediate cause for the sequence of the seque Examine Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transi Man and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) signed by the a 1 ☐Yes 2 ☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Completed cate has been a 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform this certificate 2 No 2 NO 1 Yes or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 A Matural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

Court Road, Randallstown, HD 21133

DHMH 17 Rev 1/2001

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Kafrouni

Abdallah

31. Date filed (Month, Day,

5401

32. Registrar's Signature

Old

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06316 State of Maryland / Department of Health and Mental Hygiene Kristy McRiffy 2008 1- For State Certificate of Death Reg. No. Registrar
1. Decedent's Name (First, Middle,Last)
Kristy Ann McRiffey 2. Date of Death 3. Time of Death Physician/ Month Day August 16, 2008 Year 1140 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Randallstown **Baltimore County** Northwest Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 312–54–6886 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country) Months Days Hours Min. 2/5/66 42 Director 1 M 2X F

w any	ı	10a. State MD 10b. County 10c. City, Town or Locat	Baltimore	10d. Inside City Limits 1 X Yes 2 No
/land -f shov			10f. Zip Code	10g. Citizen of What Country?
r death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	10e. Street and Number 7402 Brixworth Ct	21244	USA
with th s 23a		11. Marital Status 12. Was Decedent Ever in U.S. 13. Wa	s Decedent of Hispanic Origin? (Specify Yes or	No- 14. Race - American Indian, Black,
leath v r item	Funeral	1 Never Married 2 X Married Armed Forces? If Yes 2X No	es, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
after or	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	Yes 2 X No specify:	Specify: WITTLE 16b. Kind of Business/Industry
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036 thin 72 ne. r than ledical	Completed	12 S+ Rese	earch Assistant, Hospit	
Baltimore, MD 21215-0036 permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Harth is and Mental Hygievith in T2 hours after death with the Maryland Important: If item 27 is marked other than "natural", or items 23a or 28a-fish injury or other traumatic event, the Medical Examiner must be notified at once	ပို	17. Father's Name (First, Middle, Last) James Carter	18.Mother's Name (First, Middle Marcia Hu	
212' uld be Mental marke	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailin	g Address (Street and Number or Rural Route N	lumber, City or Town, State, Zip Code)
MD 3 id 2 shot alth and m 27 is		Albert McRiffey 740	2 Brixworth Ct, Baltim	
re, l s 1 and f Healt if item er tran		crematory or of	her place) Date	20c. Location - City or Town, State
altimore, mit Pages I an epartment of Hea iportant: If ite jury or other tr		4 Donation 5 Other Specify:		Muncie, IN
Balt permit Depart Impor injury		21. Signature of Funeral Service Licensee Victor P. Doda	Name and Address of Facility Ties L. Stevens Funera Di E. Fort Ave, Baltim	al Home, Inc.
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter	he mode of dying, such as cardiac or respiratory	arrest, shock, or heart Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Complications of sur	gery for morbid obesit	
Xaiiiiiei		or condition resulting in death) Due to (or as a consequence of):		
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8760 ificate ng phys	J/M	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 F	etal death 3 Ectopic pregnancy	23d. Date of delivery Month Day Year
Box 68760, death certificate be exenthe attending physician and for use as the burial -	Physician/Medical	past 12 months? 4 Pregnant at time of death 5 0	ther (Specify)	
D 5 8 8	Phys	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. D	id tobacco use contribute to the cause of death?
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Divipital of ours affilled i	Certification:	4 Homicide determined (Specify) unk		
Division of Vita To the Hospital or Attending Physicia within 24 hours after death. To the Funeral Director: After this ce completely filled in by the funeral direct	Medical	Certifying Physician: To the best of my knowledge, death occ (Check only one) Medical Examiner: On the basis of examination and/or investig	urred at the time, date and place, and due to the attention, in my opinion, death occurred at the time, or	cause(s) and manner as stated. date and place, and due to the cause(s)
To with	Med	and manner stated. 29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
		1/ 1. M. Big (Ta)	O.C.M.E.	August 19, 2008
		30. Name and address of person who completed douse of death (Item 23a)	444 Ponn Stroot Politimore MD 24	201
	1	Theodore M. King, Jr., MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) 32 Registrar's Signature	111 Penn Street, Baltimore, MD 21	201
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	MIT.		Decedent's Name (First, Middle, Last)					2. Date of De	ath		3. Time of Death
10	Physicia /Medic		Linda Mueller					Month OS	Da 2 3		18:01 PM
)	Examin		4a. Facility Name (If not institution, give street and num				Location of Death			. County of Dea	ath
			University of Maryland M 5. Social Security Number 6. Sex	edical (e		Baltin If Under 1 Year	If Under 24 Hrs.	8. Date of Bir		/A	dhalaa (Otata a Faraira
P	Funeral Director		212-58-1994 1□ M 2₹ F	57	Yrs.	Months Days	Hours Min.	FEB. 2	Year)	951	rthplace (State or Foreign ountry) MD
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	ems ?	Funeral		dent Ever in U.S.	13. \		Ispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No)-	14. Race - Am Black, Wh	
36	be filed within 72 hours after death with the Maryland tral Hygiene. d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 1 ☑ Yes If 1 es, Give Year or Da	2 □ No		1 ☐ Yes 2 No	Specify:	Thous, cic.,		Specify:	WHITE
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and	e d stal	Be	JOSEPH STEPALOVITCH				18. Mother's Name				
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altimore,			20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from S	20b. Plac	ce of Dispo	sition (Name of matory or other place	ce)	Date	20c. L	ocation - City o	r Town, State
Ē	Pages Iment of I tant: If Its jury or o		4 □ Donation 5 □ Other (Specify)			CREMATO	RY 8/2	6/08	GL	EN BURN	IE, MD
Bai	permit. Page Department of Important: If any injury or once.		21. Signature of Junetal Service Licensee		22	Name and Address BEL.	ss of Facility MIL			FUNERA E, MD 2	L HOME, INC.
6	F (216)		23a Part1. Epter the disease, or complications that ca shock, or heart failure. List only one cause on ea	used the death.	Do not ent					E, MD 2	Approximate
	Physician		Immediate Course (Fire)	PD							Interval Between Onset and Death
1	/Medical		resulting in death)	or as a conseque	nce of):						
	Examiner	_	Sequentially list conditions, bb.	or as a conseque	200 00:						
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09/89	icate be executed physician and the burial-transit	edical	d								
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ROX	leath certific attending p	lan/l	23b. Was decedent pregnant 1 23c. If yes, outcome in the past 12 months?	ome pf pregnand rth 2 □ Fetal d	leath 3□	Ectopic pregnancy	/		į	23d. Date of d Month	elivery Day Year
0.	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	1 ☐ Yes 2 ②No 4 ☐ Pregna 9 ☐ Unknown 9 ☐ Unkno	ant at time of dea wn	ath 5∐	Other (specify) _				World	buy Tour
	s that ined b	by Pt	Part II. Other significant conditions contributing to de-	ath but not resulti	ing in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
Vital Records,	w requires that s been signed b should be deta	ed b	Hypertension					112	Yes 2	!□No 3□!	Probably 4 Unknown
ပ္ပ	iaw re as be	Completed	Diabetes					24a. Was		24b. Were	autopsy findings available completion of cause of
<u> </u>	sician: The law certificate has t irector, page 2 s	Con						perfe 1 Yes	ormed?	death?	
VII	ician certifii ector,	Be	25. Was case referred to medical examiner? 1. To Vas. 2. To No. Hospital: 4. To L.			Oth	26. Place of Deat	h (Check only	one)		
ō	Phys r this ral dir	5	1 ☐ Yes 2 ☐ No ☐ 1 ☐ Ir 27. Manner of Death 28a. Date of		R/Outpatien 28b. Time of	t 3 DOA Oth	4 Nursing Ho	ome 5 Res			pecify)
0	nding th. : Afte e fune	tion		n, Day Year)	Injury	Wor	k? Yes 2 □ No	Zod. Describe	now inje	iry occurred	
Division	r dea rector	Certification:	3 Suicide 6 Could not be 28e. Place	of injury - At hom g, etc. <i>(Specify)</i>	ie, farm, str	eet, factory, office		28f. Location (Street a	nd Number or i	Rural Route Number,
2	ital or rs afte ral Dii led in	Cert	- Landing States	g, etc. (opeony)				Chy of 10	WII, Stat		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifice completely filled in by the funeral director, pompletely filled in by the funeral director, p.	Medical	29a. Certifier (Check only one) 1	sis of examinatio	ledge, deatl on and/or in	n occurred at the tirvestigation, in my o	me, date and place, opinion, death occur	, and due to the rred at the time	cause(s , date ar	s) and manner nd place, and d	as stated. ue to the cause(s)
	To thi within To the	Me	29b. Signature and title of certifier			29c. Licens	e number		29d. Da	ate signed (Mo	nth, Day, Year)
,	V		> S Sharkh MD	>		187	25		81	23/08	
1) [30. Name and address of person who completed cause			Print)		4	- 7		
(Sta	te	Sanober Shaikh 31. Date filed (Month, Day, Year) 32	ZZ gistrar's Signatu		reene J.	+ Baltiv	none,	10	61601	
	Registr		AUG 2 6 2008	egistrar's Signatu	So	we					

08-06288 John Person

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 27516

., 0.00		1- For State	,	Certifica	te of	Death			Reg. N	0.	3. Time of Death
Physicia dical Examii	ın/	Registrar 1. Decedent's Name (First, Mid-	dle,Last) John	Purnel	l F	erson,	Jr	N.4	ate of Death Ionth Da ugust 16, 20		1929 hrs
dicar Exami		4a. Facility Name (if not institut)	41	o. City, Town, or Lo Baltimore	ocation of D	Death	3 11	4c. County of	Death
		University Hospital	To 0 17 A	ge (In yrs. last birth	ndav)	If Under 1 Year	If Under 2	4Hrs. 8.	Date of Birth(M	M/DD/YYYY)	9. Birthplace (State or
Funeral Director		5. Social Security Number		1 7	Yrs.	Months Days	Hours	Min.	7-14-1		Foreign Country) MD
Director		215-33-1195 Usual Residence of Decedent	1 X_X M 2 F								10d. Inside City Limits
/ any		10a. State 10b. Count	у	10c. City, Town	or Locatio	n					1 X Yes 2 No
land f shov	tor	MD 10e. Street and Number	N/A	Balti	more	10f. Zip Code			10g.	Citizen of Wha	at Country?
e Mary or 28a-	Director	2908 Garris	son Blyd i	Apt T 3		21216	5		υ	S A	
eath with the Maryland items 23a or 28a-f show any ust be notified at once.		11. Marital Status	12. Was Decede	nt Ever in U.S.	13. Was	s Decedent of Hisp es, specify Cuban,	anic Origin Mexican, P	? (Specif	y Yes or No- an, etc.)	14. Race - White,	American Indian, Black, etc.
death or item	Funeral	A	Married Armed Force:	2 X No		Yes 2 X No				Specify:	Black
more, MD 21215-0036 Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. The filem 27 is marked other than "natural", or items 23a or 28a-f she mit. If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once		3 Widowed 4 15. Decedent's Education (S	Divorced If Yes, Give Year or Dates:	ompleted) 16a.	Doceden	t'e Usual Occupation	on (Give kir	nd of work		ib. Kind of Bus	siness/Industry
2 hour	Completed by	Elementary/Secondary (0-1			during m	ost of working life. I	DO NOT us	se retired)			
5-0036 iled within 72 Hygiene. d other than	ď	9th gra		N/A	St	tudent	8 Mother's	Name (Fi	rst, Middle, Mai	den Surname)	
Filed w Hygie d othe		17. Father's Name (First, Middle John Purne		Jr			Syntl	hia	Hawkir	s	
2121 nuld be fi Mental I marked	o Be	19a. Informant's Name/Relation	onship (Type, Print)	. 19	b. Mailin	Address (Street	and Numb	er or Rura	al Route Numbe	r, City or Town	n, State, Zip Code)
MD and 2 shot alth and m 27 is		Synthia Haw	kins-Mothe			Claymon			e Balt	Oc. Location -	City or Town, State
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med		20a. Method of Disposition 1 X Burial 2 Crema	tion 3 Removal from	State crema	tory or ot	her place)				- 1.	WD
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other	Specify:	Mt C	arm	el Cem_ Name and Address	of Facility	8- <u>26</u> M	-2008 larch l	Balt East F	O / MD
Balti permit. Departi Import		21. Signature of Funeral Serv		(,,	1 1	101 E.	Nort	h Av	enue	Balto	, MD 21202
Physician	\vdash	23a. Part I. Enter the disease failure. List only one ca	, or complications that caus	sed the death. Do r	not enter	the mode of dying,	such as ca	ardiac or re	espiratory arres	t, shock, or he	art Approximate Interva Between Onset and Death
/Medical		Immediate Cause (Final dise	ase a. Gunshot Wou				_				
	L	or condition resulting in deat	b. Due to (or as a co	onsequence or).				-			
	٥	Sequentially list conditions, if any, leading to immediate cause. Fitter Uncerlying Ca	Due to (or as a course	onsequence of):							
/	Examiner	(Disease or injury that initiate events resulting in death) La	ed C.	onsequence of):							
760, icate be executed physician and the burial - transit	<u> </u>		d#	l as note	ed pe	er ME G88	8/2	27/08	TT		
760, cate be executed physician and he burial - trans	Modical	UNPENDED	AMERIDED	tcome of pregnanc	v					23d. Date o	
6876 certificate ading physes as the	2/4		in the 1 Live birt	h	2 F	Ctal deall	Ectopic	c pregnan	су	Month	Day Year
Box 687 e death certific the attending p	Objection as as	1 Yes 2 No 9	Unknown g Unknow	nt at time of death	5 (Other (Specify)				<u>1</u>	
that the des	313			death but not result	ting in the	underlying cause	given in Pa	art I.			tribute to the cause of death? Probably 4 Unknown
, P.O. ires that the signed by		<u> </u>							24a. Was a		. Were autopsy findings availat
ords w requi	Silonic Siloni								autops	ned?	prior to completion of cause o death?
RecC The lav	z aße z	Ę				00 Bloom	ce of Death	(Chack o	1 Yes 2	No No	1 Yes 2 No
Vital Records ysician: The law requiring certificate has been	ector,	25. Was case referred to me examiner?	Hospital: 1 🗸 In	nationt 2 FR	/Outpatie		Other			Residence 6	Other:
≥ is side	편 15	1 Yes 2 No	28a, Date o	f Injury 28	b. Time o		jury at Wor	k?	28d. Describe h	ow injury occu	urred
on of anding Plath.	ne tuneral	1 Natural 5	Pending Aug 7, 20		016 hrs		Yes 2 ✔	No No	,		have Durel Pouto Number
Visic	in by t	1 Natural 5 2 Accident 3 Suicide 6 4 Homicide	Could not be	of Injury - At home	e, farm, st	reet, factory, office	building, e	etc.	28f. Location (\$ or Town, S 2900 Garrisor	street and Num tate) Blvd Baltir	nber or Rural Route Number, C more, MD
Dispital of pours a neral I	filled	4 Homicide		Local Street	doath oc	curred at the time	date and p	lose and	due to the caus	e(s) and manr	ner as stated.
ihe Ho iin 24 F	pletely	29a. Certifier (Check only one) 2 Medica 29b. Signature and title of C	I Examiner: On the basis o	f examination and/	or investi	gation, in my opinio	on, death o	occurred at	t the time, date	une piace;	
Division To the Hospital or Attendin within 24 hours after death. To the Functal Director: A	com	29b. Signature and title of c	and manner su	atec.		29c. Licer	nse numbe			29d. Date si	gned (Month, Day, Year)
		Pata:	anonic	a-Pol	ler	0.0	C.M.E.			August 1	ভ, ∠UUO
5		30. Name and address of p	erson who completed caus	e of death (Item 23	Ba) aminer	111 Penn 9	Street P	Baltimor	e, MD 2120	1	
)_		Patricia Aronica-F	180	nt Medical Ex gistrar's Signature					,		
Reg	Sta	CALLITY Z	7 2008 566	yes so	of the second	A STATE OF THE STA					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene rgiene Reg. No. 2008 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day PATRICK N. Month Physician SIMDN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner GALTIMONE, MODILA SECULINA HOSPI If Under 1 Year | If Under 24 Hrs. | 8, Date of Birth (Month, Day, Year)
6 7 197 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours 1√2 M 2□ F 265-69-5083 Director N.Y. Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Enaminal must be notified at 1 ☐Yes 2 ▼No Director Burtonsville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20866 U S 3 Crosswood Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify: Specify: þ Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled llth grade Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patricia Brown Raymond Simon ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3 Crosswood Court Burtonsville, MD 20866 Cynthia Brown-Jones-Sister 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fair Lawn Memorial 8-29-2008 Fair Lawn, N. J. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Glad Waner Balto, MD 21202 Avenue 1101 E. North 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPSIS **Physician** /Medical Due to (or as a consequence of): Examiner HERATITI Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner CHOREA certificate be executed HUNTINGTON and Due to (or as a consequence of) Box 68760, attending physician Physician/Medical the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No P.0. the detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ pe MALNUTIZA TION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed peen a 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an has page 2 autopsy performed? Yes 2 No 6-TUBE certificate 1 ☐ Yes the Hospital or Attending Physician: hin 24 hours after death. the Funeral Director: After this certific mpletely filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier moghbely, mu STOR W. BALTIMARKE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MOGH MY MI ad: 32/Registrar's Signature JANFT U. GALTIMONE MD 31. Date filed (Month, Day, Year). State Registrar

			State of Maryland		artment of F		and Me	-		711118	27519
			Registrar 1. Decedent's Name (First, Middle, Last)		tineate or	Death	2	. Date of De			3. Time of Death
	Physicia		Frederick Caranda	ues	Sese			Month	2(2)	2008	-08594M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	r Location of	f Death	0	4c. 0	County of Deatl	1
<i>.</i> .			Anne Avandle Waker Co	ntor	If Under 1 Year	16 Under 2	JU!	Data of Pin	<u> </u>	AA	anless (Clate or Foreign
	Funeral Director		5. Social Security Number 6. Sex 1 M M 2 □ F 7. Age (In yrs. la 34	st birthday) Yrs.	Months Days	Hours	Min.	Date of Bird (Month, Date of 21	y, Year) • 197	TAP TAP	nplace (State or Foreign Shington
	יסי		Usual Residence of Decedent			1		701 21	9 19/	טע בי	
	arylan show	Ē		Town or Lo	cation						10d. Inside City Limits 1 ☐ Yes 2 🗓 No
	he Ma 28a-f	Director	10e. Street and Number	Bowie	10f. Zip Code			1	10a Citiz	en of What Co	
	with with the sa or	i Dir	12117 Maddox Lane		2071	5			J	ed Stat	•
	death ms 2;	Funeral	11 Marital Status 12. Was Decedent Ever in U.S.	. 13.1	Was Decedent of H	Hispanic Orig	gin? (Speci	fy Yes or No		4. Race - Ame	rican Indian,
0	filed within 72 hours after death with the Maryland Hygiene. Ither than "natural", or Items 23a or 28a-f show ent, the Medical Examinat must be redified at		1 Mever Married 2 Married 1 1 Yes, 2 Mo No If Yes, Give		fYes, specify Cuba 1 □Yes 21☑No	Specify:	, ruello nii	Jan, etc.		Black, White As Specify: Pac	ian ific
2-003p	hours ural",	ed by	3 □ Widowed 4 □ Divorced Year or Dates:		dent's Usual Occup					d of Business/l	
	in 72 n "nat	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	kind of work done DO NOT use retired	during most	of working		TOD. IXII	d of Business/i	nadotty
7	d with giene er tha	Com	Elementary/Secondary (0-12) College (1-4or 5+)	Water	Testing	Speci	ialist	-	Wa	ater Te	sting
and	pe file tal Hy d othe	Be	17. Father's Name (First, Middle, Last)					First, Middle,			
<u> </u>	d Men marke	2	Ricardo Sese					a Car			T. O. (1)
2	d 2 sh th and 17 is n traun		19a. Informant's Name/Relationship (Type. Print) Angelita Sese		ng Address <i>(Street</i> Hol i day					20817	up Gode)
ည် .	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.		200 Method of Disposition 20h Pis	ace of Dieno	eition (Name of		Dat			cation - City or	Town, State
Daltimor	Pages nut: If I		1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State Cne 4 ☐ Donation 5 ☐ Other (Specify)	sapea mator	natory or other place ke y, Inc.	ce) :	3/23/2	2008	Belt	tsville	, MD
= 0	permit. Departri Importa any inju		21. Signature of Europeal Service Licensee	22 R	. Name and Addre	-	Crema	ation	Svcs	ria	
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			23a. Palt4. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line.	Do not ent	er the mode of dyi	ng, such as	cardiac or	respiratory a	rrest,		Approximate interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	11	hemo	relag	e				Iday
	/Medical Examiner		Due to (or as a conseque	nce of):							
		Jer	Sequentially list conditions, if any, leading to immediate cause. Liner Unidentifying Cause (Disease or injury	ence of):							
	ransit	Examiner	that initiated events C.								
5	oe exe	EX	resulting in death) Last Due to (or as a consequence)	nce of):							
00/00	physic the b	dical	d								
XO	To the postpla of varianting Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23c. If yes, outcome of pregnant						2	3d. Date of del	iverv
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'n	es ma igned be de	by	Part II. Other significant conditions contributing to death but not result	ing in the u	nderlying cause giv	ven in Part I.					the cause of death?
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ב ב	has the great specified and th	Completed						24a. Was auto		24b. Were au prior to death?	topsy findings available completion of cause of
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>	ysicia is cert directo	0 8	examiner? 1 Yes 2 No Hospital: 1 Nopatient 2 E	R/Outpatier	ot 3 🗆 DOA Oth	205:		Check only o		Other (Spe	cify)
	ter thi	T:U		28b. Time of				d. Describe			
5	eath. or: Ai	catic	2 Accident investigation		M 1	Yes 2□	No				
	or An offer d Direct in by t	Certification: T	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At hom building, etc. (Specify)	ne, farm, str	eet, factory, office		28	f. Location (City or To			ural Route Number,
	ours sours source		29a. Certifier 1 Certifying Physician: To the best of my know	rledge, deat	h occurred at the t	ime, date an	nd place, ar	nd due to the	cause(s)	and manner a	s stated.
1	re nos 1 24 h re Fur pletely	edical	(Check only 2 Medical Examiner: On the basis of examinatione) and manner stated.	on and/or in	vestigation, in my	opinion, dea	th occurred	d at the time	, date and	place, and due	e to the cause(s)
į.	within To th comp	Me	29b. Signature and title of certifier		29c. Licens					e signed (Mont	
			If Telem my		D 3	2480	Y		8	-20-	2008
			30. Name and address of person who completed cause of death (Item		Print)	1	1.	1000-1		11.1.	2008
	√/ Sta	te	Robert T Veterson mg 31. Date filed (Month, Day, Year) \$32. Registrar's Signatu		<u> </u>	1 8	1110	To fice	>	rud ,	
	Registra		31. Date filed (Month, Day, Year) 32. Registrar's Signatu	Sport	w						

Registrar

State

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WATSON

31. Date filed (Month, Day, Year)

AUG 2

MAP

MIZPATRICK

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

3altimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

100

32 Registrar's Signature

NURTH WEST

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HOSPITM

26,

2002

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST £6. 2008 25:22A Deborah Lee Simmons /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Months Director 58 214-54-3633 11/11/1949 Maryland Usual Residence of Decedent the Maryland 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location "natural", or Items 23a or 28a-f show 1 ☐Yes 2X No Director Maryland Baltimore Essex 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or ury or other traumatic event, the Medical Exemiting 1, ust be a 401 Delaware Avenue 21221 Funeral S. Α. Was Decedent Ever in U.S. Armed Forces?
 1 ☐ Yes 2 Mo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify. If Yes, Give Year or Dates þ Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ Jack LoValvo Mary Carter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If Item 27 is any Injury or other trau once. Larry Steven Simmons (Husband) 401 Delaware Avenue Essex, Maryland 21221 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 8/29 2008 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Overlea, Maryland of Faith Cemetery Gardens ^{22. Name and Address of Facility} Bruzdzinski Funeral Home 1407 Old Eastern Avenue 21. Signature of Funeral Service Licensee PA Essex, Maryland 21221 Ecclod 23a. Part 1. Enter the disease, or implication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) RESPIRATORY FAILURE /Medical Due to (or as a consequence of): Examiner ASPIRATION Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Dualto (or as a consequence of) signed by the attending physician and I be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 687 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Day Year Month 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown After this certificate has been s funeral director, page 2 should MAJOR DEPRESSION 24b. Were autopsy findings available prior to completion of cause of death? SEIZURE DISORDER 24a. Was an autopsy perform 2. No 1 ☐ Yes 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 □ No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 Pending investigation death. 1 🗆 Yes 2 🗌 No within 24 hours after death

To the Funeral Director: / 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 00 g. D37254 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year)

AUG 2 7 20 7671 05 ER DRIVE TOWSON, MARYLAND 21204 State 2008 Registrar

DHMH 17 Rev 1/2001

			. For	Type or Print in BI State of Maryland						•		е		07500)
			State Registrar			Cer	tificate of L	Death			Reg. No	<u> </u>	8	27522	
	Physici	an	1. Decedent's Name (First, Middle, Last							2. Date of De		ž, 2č	808	3. Time of Death 12:45A M	
	/Medic	al	Charles Edgar '				4b. City, Town, or	Location of		Aug.		c. County of		12:4JA W	_
1	Examin	ier	Gilchrist Hosp	ice	t brinth	odou)	Towson			Data of Bi		Balti	mor		
	Funeral Director			M 2□ F 85		rs.	Months Days	Hours	Min.	B. Date of Bit (Month, D. L. 1/20	/19	22	Count	ace (State or Foreigr ry)	_
	Maryland a-f show	ctor	MD Baltime	ore Bal									10	od. Inside City Limits 1 □ Yes 2 No	
	h with the 23a or 28 st be not	Funeral Director	10e. Street and Number 1101 Hart Rd.				10f. Zip Code 21286				10g. C	itizen of Wha	it Count	ry?	
2-003e	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menalt Hygiene. Important: I firem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I to Medical Exagination on the natified in once.	β	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1			/as Decedent of H Yes, specify Cuba ☐ Yes 2 No	ispanic Orig in, Mexican, Specify:	gin? (Spec , Puerto Ri	ify Yes or No ican, etc.)	D-	14. Race - Black, Specify: V	White, et	tc.	
7.0.7	nin 72 ho e. In "natur Wedical	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+)	16a. l	Deced Give k life. D	ent's Usual Occup kind of work done o O NOT use retired	ation <i>luring most</i> l)	of working	7		Kind of Busir		ustry	
7	ed with ygiene ier tha t, the	Com			En	gir	neer				L	rospa	ice —		
yland	uld be file Mental H Irked oth	To Be	17. Father's Name (First, Middle, Last) Charles Edgar	Thomas Sr.						Rober		n Surname) n			
Mar	nd 2 sho alth and I 27 is ma ir trauma	i	19a. Informant's Name/Relationship (T) Sarah D. Thomas	1			g Address <i>(Street a</i>							^{Code)})305	
more,	Pages 1 a lent of Hea nt: If item ry or othe		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	nemoval nom State i			ition (Name of atory or other place ake Crei	e) Au	1g. 2			ocation - Ci			
pallimor	permit. Departm Importa any Inju		21. Signature of Funeral Service Licens		3	22.	Name and Address	ss of Facility	CAF					mann P.A), 21286	Ą
A. F	Physician /Medical		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ne cause on each line. a.	C	ot ente		g, such as	cardiac or	respiratory a	arrest,			Approximate Interval Between Onset and Death	ر
E	Examiner		f	Due to (or as a conseque	nce of	f):									
-	E WE	Examiner	Sequentially list conditions, it is, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Cue to (unas a ourseque	noù of)·									
6	sician and burial-trai	al Exar	that initiated events resulting in death) Last	Due to (or as a conseque	nce of	j):				·					_
O. DOX 001	the hours after death. This 24 hours after death. The Funeral Director: After this certificate has been signed by the attending physician and pletely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medio	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnand 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath		Ectopic pregnancy Other (specify)	<i>y</i>				23d. Date of Month		ry Day Year	
cords, r.	requires mat me or been signed by the should be detached	by	Part II. Other significant conditions con	ntributing to death but not resulti	ng in	the un	derlying cause give	en in Part I.			tobacco Yes 2			e cause of death? ably 4 🗌 Unknown)
ם ביים	Attending Prysician: The law requir or death: ector: After this certificate has been s by the funeral director, page 2 should	Completed		·			-			24a. Was auto perfo 1 □Yes		prid dea	or to con ath?	osy findings available npletion of cause of 2 🗆 No	1
N	certific ector,	Be	25. Was case referred to medical examiner?	Hospital:			Othe			Check only				11.	_
5 8	r this	2	1 Yes 2 No	1 Inpatient 2 El	R/Outp 8b. Ti			4 LI NUI				6 Other ury occurred	(Specify	otospic	_
	ath. or: Afte	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Year)	In	jury	28c. Injur Work M 1 🗆	(? Yes 2□N	No						
	io the nospital of Attenol within 24 hours after death. To the Funeral Director: A completely filled in by the ft	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	e, farr	n, stre	et, factory, office		28	Bf. Location City or To	(Street a wn, Sta	and Number te)	or Rurai	Route Number,	
	vithin 24 hours after or to the Funeral Direction of the Direction of the funeral Direction of the Direction of the Direction of the Direction of	Medical (rsician: To the best of my knowl iner: On the basis of examination and manner stated.											
	vithis To th	Ž	29b. Signature and title of certifier	Melyin	W	•	29c. Licenso	52	05		- 1	ate signed (Day, Year)	,

State

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ı	S Regis	itate strar

	1 - State Registrar				Ce	rtificate of	Death	100: 1=		2008	
sician	1. Decedent's Nam	e (First, Midd		mī				2. Date of De Month	Day	2008	3. Time of Death 9:22 p. M
edical	Doris 4a Facility Name (If not inetitutie	Marjean on, give street and nur		omas	4h City Town	or Location of Dea	August		County of Deal	
niner	, ,		ow Street	ilber)		Riverda			1	ince G	
	5. Social Security N		6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs		rth	9. Bir	thplace (State or Foreigountry)
•	579-26-9		1□M 2□F	83	Yrs.	Months Days	Hours Will	May 20	, 192	25 Wa	shington, I
	Usual Residence o	f Decedent 10b. Count	v	10c. Ci	ty, Town or Lo	cation					10d. Inside City Limits
힏				Die	1 . 1 .						1 ⊟Yes 2 ⊟xNo
To Be Completed by Funeral Director	MD 10e. Street and Nu		ce Georges	KIV	erdale	10f. Zip Code			10g. Citiz	zen of What Co	ountry?
a D	5806 Lo	ngfello	ow Drive			20737			Unit	ed Sta	tes
Funeral Director	11. Marital Status	0 -		dent Ever in U	.S. 13.	Was Decedent of	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or Norto Rican, etc.)	0- 1	14. Race - Ame Black, White	
Y.F.	1 Never Mari		rried 1 □Yes	2 /2 No		1 □Yes 2 □ No		, , , , , , , , , , , , , , , , , , , ,		- "	
ed by	3		d Year or Da	ates:		21				M n of Business	ite
olete		cify only high	ent's Education est grade completed)		(Give	dent's Usual Occu kind of work done DO NOT use retire	e during most of wo ed)	orking	160. KII	iu oi businessi	/IIIdusti y
Completed	Elementary/Seco	ondary (0-12)	College (1	-4or 5+)		tionist	,		Rat	ilroad	
Be C	17. Father's Name	(First, Middle	e, Last)		*			me (First, Middle		Surname)	
P	William	Henry	Dailey				Sara El	len Ecto	n		
ľ	19a. Informant's N						t and Number or F				
	Jackie		mas (daug				low St.		,		
	20a. Method of Dis		3 ☐ Removal from	State 20b.	Place of Dispo cemetery, crei	osition (Name of matory or other pla	ace) Au	Date gust 25,		cation - City or	
		-	3 □ Removal from S Specify)	Che	sapeak	e Cremat	ory 2	008	per	tsville	
	21. Signature of F	unienal Servici	e Licensee	1100000	. 2	2. Name and Addr	Raility Ave. Sil	pp Funer	al &	Cremat	ion Servic
	23a Part1 Enter	the disease	or complications that c	M00982						.ID 2071	Approximate
	shock, or he	art failure. Lis	st only one cause on e	ach line.				io or roop natory	arroot,		Interval Between Onset and Death
	disease or condition resulting in death)	on	a	or as a consec		Metastas	18				
			. Due to	or as a consec	quence on.						
ner	Sequentially list co if any, leading to in Cause (Disease or	onditions, nmediate	Due to (or as a consec	quence of):						
Examiner	that initiated event	Ş	c								
	resulting in death)	Last	Due to (or as a consec	quence of):						
dica			d								
/Me	IF FEMALE:		23c. If yes, out	come of pregn	ancy					201 D (1	P
cian	23b. Was deceder in the past 12	months?	1 ☐ Live I	oirth 2 Feta	al death 3[☐ Ectopic pregnar ☐ Other (specify)			-	23d. Date of de Month	Day Year
Physician/Medical	1 ☐ Yes 2 9 ☐ Unknown		9 ☐ Unkn								
	Part II. Other sign	ificant condit	tions contributing to de	eath but not res	sulting in the u	inderlying cause g	iven in Part I.	23e. Did	tobacco u	se contribute t	o the cause of death?
ed by	Osteop	orosis						1 🗆	Yes 2	₹ No 3 🗆 P	robably 4 🗆 Unknow
Completed	Conges	tive H	eart Failu	re				24a. Wa		24b. Were a	utopsy findings availal completion of cause of
mo								perl 1 □ Yes	opsy formed? 2 🗷 No	death?	_
Be C	25. Was case refe examiner?	rred to medic	al				26. Place of De	eath (Check only			
	1 Tes 2 ∑] No	Hospital:	npatient 2		III 3 LI DOX		Home 5 Res	sidence (6 □Other (Spe	ecify)
Certification: To	27. Manner of Dea 1 Natural	th 5 ☐ Pend	28a. Date ing (Mon	of Injury th, Day, Year)	28b. Time o Injury	Wo		28d. Describe	how injur	y occurred	
cati	2 ☐ Accident 3 ☐ Suicide	inves 6 ☐ Could	tigation	-,			□Yes 2 No				
ř	4 Homicide		mined Zee. Place	of Injury - At n ng, etc. <i>(Sp</i> ec	ify)	reet, factory, office		City or To	(Street an own, State	d Number or H)	Rural Route Number,
Ö	29a. Certifier	1 Certify	ring Physician: To the	best of my kn	owledge, deat	th occurred at the	time, date and pla	ce, and due to th	e cause(s)	and manner a	as stated.
	(Check only one)	2 Medica	al Examiner: On the b and man	asis of examin ner stated.	ation and/or in	nvestigation, in my	opinion, death oc	curred at the time	e, date and	place, and du	e to the cause(s)
		title of certifi	ier /	0			nse number		-	e signed (Mon	th, Day, Year)
Medical	29b. Signature apo	/ -				10			11 . 1		
	29b. Signature and	Quic	14 F	ten	0.	1)(9609		Xi	25-0 8	3

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 305 PM **Physician** Mildred Virginia Vaught 2000 /Medical 4c. County of Death wn, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Itemore. d2ath Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/07/1934 ge (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 🕱 F 74 MD 579-40-9489 Director Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or items 23a or 28a-f show Baltimore 1 ☐ Yes 2 No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21227 USA 3225 Tartarian Ct. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. other than "natural", or ite 1 ☐Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 □Yes 2 X No Specify \$ 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home 9 Homemaker h and Mental Hygie 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event once. Be Jesse Brown Spitzer Christine Unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3225 Tartarian Ct. Balt. MD, 21227 Linda Vaught/Daughter ^{Date} 27, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Mt. Carmel Cem. 2008 22. Name and Address of Facility CAFA/Stephen D.Lohrmann P.A. 21. Sigrature of Funeral Service Licensee M01443 8717 Green Pastures Dr. Balt. MD,21286 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (r as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) The law requires that the death certificate be executed and Due to (or as a consequence of) Box 68760. attending physician Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnar in the past 12 months? 3 Ectopic pregnancy Day Month Year 5 Other (specify) ☐Yes 2 No P.0. the 9 Unknown 9 Unknown ò 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, \$ 2 No 3 Probably 4 Unknown 1 🗌 Yes page 2 should Completed were autopsy findings available 24a. Was an has prior to completion death?
1 □ Yes 2 ☑ No certificate 1 ☐ Yes Division of Vital Phospital or Attending Physician: 24 hours after death.
Funeral Director: After this certific. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 19 No 1 Dinpatient Certification: To 2 ER/Outpatient 3 DOA 27. Mann of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 atural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated. within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

31. Date filed (Month, Day, Year)

AUG 2

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Caton Ave Bultimore

M.D

3. Himle and address of person who completed cause of death (Item 23a) (Type, Print)

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2008

32 Registrar's Signatu

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State of Maryland Poepartine of Health and Mental Aydene State of Maryland Poepartine of Health and Mental Aydene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Month Year August 17:58 PM GILBERT WOHL 23 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner of Hespital N/A Divai Baltmine Baltimore 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/20/1916 Social Security Number **Funeral** Days Hours 218-09-5964 91 **Director** Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1 □Yes 2 No MD BALTIMORE OWINGS MILLS Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8019 VALLEY MANOR ROAD 21117 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑Yes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Specify: WHITE 1 ☐ Yes 2 🖾 No Specify. \$ If Yes, Give Year or Dates: 3 Nidowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN SH0ES 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) **JOSEPH** GOLDSTEIN WOHL SARAH 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JOEL WOHL / SON 1664 BULLOCK CIRCLE, OWINGS MILLS, MD 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 08/25/2008 ROSEDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BRUS., INC. 21. Signature of Funeral Service Licensee Malt 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) contusions 3 days brain /Medical Due to (or as a consequence of): Examiner 3days traumatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of ESTREAMENT NO PROPERTY OF MELTIN signed by the attending physician and I be detached for use as the burial-tran Due to (or as a consequence of): 开公公十 Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy Year in the past 12 months? Month Day 5 Other (specify) 1 □Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ Thrombocytopenia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performe this certificate 2 No 1 🗌 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Yes 2 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To Division of After thi funeral 28a. Date of Injury (Month, Day, Year) ne Hospital or Attending Pl n 24 hours after death. Re Funeral Director; After the pletely filled in by the funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending SUBTECT HAD PALL UNKNOWNM 1 ☐ Yes 2 No investigation 2 X Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State 20 Crossroads Drive Owings Mills, MD 4 Homicide determined To the Hospital or within 24 hours af To the Funeral Di completely filled in PARKING 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD August 23 ormer D0063219 30. Name and a dress of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE 2401 W. BOWEDERT AVE BALTIMORE SINAL ONWAT HOSPITAL OF 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

08-06414 Jazmine Warr Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

zmine Warr		State of Maryland / Depart	tment of l ificate of i		lental Hy	giene Reg. l	200	8 27526		
Physicia edical Examin	an/	1. Decedent's Name (First, Middle,Last)				2. Date of Death	av Year	3. Time of Death 0050 hrs		
edicai Examii		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death					4c. County of Death			
		Shady Grove Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. las	t hirthday)	Rockville	Linder 24Hrs	8. Date of Birth (Montgomery MM/DD/YYYY) 9. Bir	rthplace (State or		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. las	Yrs.		loure Min	APR.7,	Foreig			
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, T	own or Locatio	on				10d. Inside City Limits		
*	ь	MD FREDERICK U	RBANIA	Α				1 X Yes 2 No		
or 28a-f	Director	10e. Street and Number 3250 SugarLoaf Pkwy F03/1	2	10f. Zip Code 21704			Citizen of What Cou	intry?		
215-0036 be filed within 72 hours after death with the Maryland ntal Hygeine. rked other than "natural", or items 23a or 28a-f sho ent, the Madical Examiner must be notified at once.		11. Marital Status 12. Was Decedent Ever in U.S.	. 13. Was	Decedent of Hispanio		cify Yes or No-	14. Race - Amer White, etc.	rican Indian, Black,		
	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No		es, specify Cuban, Mex		Rican, etc.)		CV		
urs afte tural",	d by	3 Widowed 4 Divorced If Yes, Give Year 1 Yes No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work					ne Specify: BLACK 16b. Kind of Business/Industry			
21215-0036 uld be filed within 72 hours after Mental Hygiene. marked other than "natural", c event, the M died. Examiner.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during mo	ost of working life. DO	NOT use retire	ed)				
5-003 iled within Hygiene. I other th	mo:	4 TH 17. Father's Name (First, Middle, Last)	STUL	DENT	lother's Name ((First, Middle, Ma	SCHOOL iden Surname)			
21215-0036 build be filed within 7 Mental Hygiene. marked other than ic event, the M die.	Be	NOBERT K. WARR								
MD 21 d 2 should I th and Men n 27 is man	٩	19a. Informant's Name/Relationship (Type, Print)		Address (Street and			•	111		
e, MD 2121 I and 2 should be f Health and Mental item 27 is marked			lace of Disposi rematory or oth	tion (Haine of cometer	spire	Date Date	BOWLE - M 20c. Location - City o	Town, State		
Baltimore, permit. Pages I a Department of He Important: If ite		To build 2 Clemation 3 Removaliton State	-	CEMETERY	Z Aug	.29,20	08 Lando	20785 ver,Md.		
Baltimore, MD 21 permit. Pages I and 2 should Department of Health and Me Important: If item 27 is mainjury or other traumatic ev		21 Astura of Europea Somica Licenses	22. N. Cō	ame and Address of F	Scrug	gs fune	eral Hom	е		
Physician		22. Name and nature of Porterial Service Encersee Calvin B. Scruggs funeral Home Calvin B. Scr								
/Medical Fxaminer		Immediate Cause (Final disease a. Head and Neck Injuries Death								
		or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, b.								
	iner	if any, leading to immediate Due to (or as a consequence of):								
red nsit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
50, te be executed ysician and burial - transit	ledical									
68760, certificate be nding physici se as the buri		IF FEMALE: 23c. If yes, outcome of pregn 23b. Was decedent pregnant in the		tal dooth 3 F	Ectopic pregna	ncv	23d. Date of delive	Day Year		
Records, P.O. Box 68760, The law requires that the death certificate be executed care has been signed by the attending physician and page 2 should be detached for use as the burial - transi	Physician/IV	past 12 months? 4 Pregnant at time of death 5 Other (Specify)								
J. Box t the death c by the atten	Phys	Part II. Other significant conditions contributing to death but not re	sulting in the u	underlying cause giver	n in Part I.	23e. Did tob	acco use contribute f	to the cause of death?		
ires that the signed by	d by					1 Yes		robably 4 Unknown		
of Vital Records, g. Physician: The law requir. The rule cretificate has been so neral director, page 2 should!	Completed					24a. Was ar autops perforn	y prior to	autopsy findings available ocompletion of cause of		
	Com			00.70	Death (Check of	1 ✓ Yes 2				
/ital /sician: nis certi director	Be	25. Was case referred to medical examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓	ER/Outpatient	lOth	or:		tesidence 6 Oth	ner:		
≞ . < æ	on: To	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of I	Injury 28c. Injury at			ow injury occurred uto auto collisio	n		
Division ospital or Attendin hours after death.	Certification:	2 Accident Investigation 28e, Place of Injury - At ho				28f. Location (St	reet and Number or	Rural Route Number, City		
Div pital or ours aft teral Di	Serti	4 Homicide				or Town, Sta Interstate 270 i	or Town, State) erstate 270 near Route 28, Rockville, MD			
		29a. Certifier (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)								
To the within To the comple	Medical	and manner stated. 29b. Signature and title of certifier		29c. License nu			29d, Date signed (A			
		Jacha Jegus		O.C.M.E	E.		August 22, 200)8		
		30. Name and address of person who completed call of death (Item Tasha Greenberg MD. Assistant Medical Exam		Penn Street, Ba	altimore Mr	D 21201				
S	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signatu								
Regis	strar	AUG 2 7 2008 Marian A	F 6408							

Amend #26, per MD 5882 8/27/08 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 7527 Certificate of Death 3 Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Dav Year **Physician** 4:45 pm 2008 Williams /Medical 4a. Facility Name (If not institution, give street and number)
112 S. Catherine St 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore treet If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex last birthday **Funeral** Months Hours Min. Days 48 1□M 2**√**F Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan enert of Health and Mental Hygiene.
Instit If Nem 27 is marked other than "natural", or items 23a or 28a-f show any or other than that the Medical Examiner must be notified at any or other traumatte event, the Medical Examiner must be notified at 1 XYes 2 ☐ No Baltimore MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21223 USA 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Tes 2 No If Yes, Give Year or Dates: 1X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Black Completed by 3 Widowed 4 Divorced 16b. Kind of Business/Industry i. Decedent's Usual Occupation (Give kind of work done during most of working vife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Elementary/Secondary (0-12) College (1-4or 5+) pervisor orb; 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maider Be ပို 19a. Informant's Name/Relationship 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
932 S. Paca St., Baltimore, MD 21230 Clayborne Daughter Baltimore, position (Name of rematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □Cremation 3 □F 4 □Donation 5 □ Other (Specify) 3 Removal from State Department o Important: If any Injury or 8.30.08 21. Signatural Funeral Service Licenses Value and Address & Facility (eeg Pile (21229) 5/5/ Balto. Nat'1 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Month Cell Luns non- small /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): Records, P.O. Box 68760, physician Physician/Medical the as attending IF FEMALE nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month for in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4□Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1€ Yes 2 No 3 Probably 4 Unknown cate has been signated page 2 should be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate I 2 No Division or Vital the Hospital or Attending Physician: hin 24 hours after death.

the Funeral Director: After this certific

mpletely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onli one Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🔲 Inpatient 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1-PNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 4E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within ? 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number n 6275 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21229 Ave LL Karan 32. degistrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2008

State of Maryland / Department of Health and Mental Hygiene giene Reg. No. 2008 1 - For State Registrar 27528 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** AUGUST ^{Day} 25 2008 8:00P M ELIZABETH A. WAUGH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1604 Greenspring Avenue Baltimore Lutherville 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Jan.23.1937 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2√ XF Days Hours Maryland 215-34-1288 Yrs Director Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Item 27 is marked other than "natural", or items 23a or 28a-f shot other traumatic event, the "Actical Examiner must be rediffed at 28a-f show Baltimore Maryland Baltimore County Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1604 Greenspring Avenue 21093 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White by Specify: ¥ Widowed 4 □ Divorced and Mental Hygiene. Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Homemaking →Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Zabel Elsie Hancock 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If Item 27 is any Injury or other tra once. 412 Lees Mill Rd. Hampstead, Maryland 21074 Cheryl L. Dively (Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Pages 1 X ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Dulanev Valley M.G. 8-28-2008 Baltimore, Md. 4 Donation 5 Other (Specify) 22. Name and Address of Facility Lassahn Funeral Home 7401 Belair Rd. Baltimore, Maryland 21. Signature of Funeral Service Licensee 21236 23a. Part 1. Enter the disease, or complicate shock, or heart failure. List only one of Approximate Interval Between Onset and Death ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Coronar **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for sels consequence of The law requires that the death certificate be executed attending physician and for use es the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) P.O. signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s certificate har rector, page 2 autopsy performed? 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home Residence 6 Other (Specify) this Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After thi funeral 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Division Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes ours after death.

neral Director: A
filled in by the fu 2 No 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital within 24 hours a

To the Funeral I

completely filled 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

[2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Shunder D- Physician D39758 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9114 Pm adelphia RD. Suite 300 BAOTO ND 21237 Keum Schendel 31. Date filed (Month, Day, Year) 22. Registrar's Signature State Registrar

M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 3.35 AM William Leonard Warfield, Sr. AUGUST 23 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Keswick Home Baltimore 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 X M 2 □ F May 3, 1919 Director 219-07-7885 89 Maryland Usual Residence of Decedent 10c, City, Town or Location 10d. Inside City Limits 1∩a State 10b. County "natural", or Items 23a or 28a-f show dical Examiner must be notified at Director 1 ☐Yes 2 X No MD Carrol1 Finksburg 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2712 Wildorlyn Drive U.S.A. 21048 filed within 72 hours after death v Hygiene. other than "natural", or Items 23s Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 X Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify Specify: ģ 3 Widowed 4 Divorced White Completed the Medical 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Repairman NCR permit. Pages 1 and 2 should be filed in Department of Health and Mental Hygic Important: If Item 27 Is marked other I any injury or other traumatic event, the 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Warfield Cora Bell Marshall ပ George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Margaret Warfield Finksburg, MD 21048 Wife 2712 Wildorlyn Drive 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) St. Thomas Cemetery |8/26/08 Owings Mills, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 11824 Reisterstown Road Sin ELINE FUNERAL HOME Reisterstown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician DEMENTIA ADVANCED disease or condition resulting in death) TKION /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate the first line of the cause (Disease or injury that initiated events Due to (or as a consequence of) Examine certificate be executed attending physician and for use as the busing resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No Yea 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) Division or Vital Records, P.O. 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has autopsy performed? Yes 2 No certificate 1□ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA | Other: 4 | Mursing Home 5 | Residence 6 | Other (Specify) 1 Yes 2 No P After this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident fter death 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

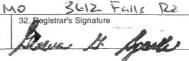
State Registrar

31. Date filed (Month, Day, Year) AUG 2 7 2008

S. Salvi

29b. Signature and title of certifier

Dulicet



MD

30. Name an Taddress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

De059056

Belt MO

29d. Date signed (Month, Day, Year)

3125 08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** AUG **083** ™ 2008 Shan /Medical give street and number) 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, Examiner Salver OVIn Crest 8 Date of Birth (Month, Day, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Hours Year) Months Days Min. 1 **X** M 2 □ F Yrs. December 13, 1984 Maryland Director 23 213-08-2417 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits la or 28a-f show t be notified at 10b. County 10c. City, Town or Location 1 ☐ Yes 2 X No Director Silver Spring **Maryland** Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number ms 23a II.S.A. 20903 5 Crest Park Court Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 11 Marital Status Black, White, etc. an "natural", or iten Medical Examiner 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Education Student. Pages 1 and 2 should be filed v ment of Health and Mental Hygie ant: If Item 27 Is marked other t 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Gnanakkan Raj Abel 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5 Crest Park Court, Silver Spring, Maryland 20903 Raj Abel - Father If Item 27 or other 1 Saltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any injury or conce. 1 x Burial 2 ☐ Cremation 3 ☐ Removal from State George Washington Cemetery 08/12/2008 Adelphi, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility **Hines-Rinaldi Funeral Home, Inc.** 21. Signature of Funeral Service Licenses 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part1. Enter the disease, or complications that caused the death. Do not ever the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 169 アノ 310 /Medical Due to (ras a / nsequence of): Examiner Sequentially list conditions, and sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner death certificate be executed burial-transi and Due to (or as a consequence of): physician Box 68760 Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) P.O. ed by the a 9 I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: Hospital or Attending 1 Natural 5 Pending investigation A 4 7 2008 1 ☐ Yes 2 No death. 2 Accident after death 6 ☐ Could not be 28f. Location (Street and Number or R. City or Town, State) 5 3 Suicide 4 ☐ Homicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) Kome MD 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. To the within 2 29c. License number 29d. Date signed (Month, Day, Year) ature and title of certifier D 20458 MOME

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 (2)

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32 Registrar's Signature

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31. Date filed (Month, Day, Year)

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			For State Registrar	State of Mar	yland / Dep <i>Ce</i>	artment of F ertificate of	lealth and N <i>Death</i>	lental Hyq ا	giene Reg. No. 20	08	27531
			1. Decedent's Name (First, Middle, La	st)		-		2. Date of Dea		Voor	3. Time of Death
2	Physici /Medio	_	1 Ton Alexander 9 2000							3	3:54pm M
	Examin	er	4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death								
-	Funeral	-	APEX HEALTH OF SI 5. Social Security Number 6.5		In yrs. last birthday	SILVER S	If Under 24 Hrs.	8. Date of Birt	MONTG		ace (State or Foreign
ь	Director		577-88-4834	1□M 2√F	43 Yrs.	Months Days	Hours Min.	(Month, Day			ngton, DC
	put w		Usual Residence of Decedent 10a. State 10b. County		Oc. City, Town or L	ocation					d. Inside City Limits
	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If it item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Director			,					10	Yes 2 No
			DC 10e. Street and Number		Washingt	10f. Zip Code			10g. Citizen of	What Count	ry?
		al Di	506 Allison Stree	t		20011		1	United :	States	
36	ems 2	To Be Completed by Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S. 13.	Was Decedent of H	lispanic Origin? (Sp			ce - America	ın Indian,
	urs after al", or ite xamine		1 ★ Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	Trioditi, 0.0.)		y: Blac	
21215-0036	72 hot natura lical E		15. Decedent's E (Specify only highest gr	ducation	16a. Dece	edent's Usual Occup	oation	kina	16b. Kind of B	usiness/Indu	ustry
2	ithin 7 ne. nan "r		Elementary/Secondary (0-12)	College (1-4or 5+)	·	e kind of work done DO NOT use retire	d) most or worl	(ing			
2	lled w Hygier her th		11 17. Father's Name (First, Middle, Last		Sale	es Clerk	18. Mother's Nam	o /Final Alimbila	Private		
anc	d be fi		• • • • • • • • • • • • • • • • • • • •	,			Reba A1	, , ,	maiden Surnar	nej	
Maryland	shoul nd Me mark		Alfonso Alegria 19a. Informant's Name/Relationship	Type. Print)	19b. Mail	ing Address (Street			er, City or Town,	, State, Zip (Code)
Ĕ	and 2 alth a 27 is		Reba Alegria / Mo	ther	506 A	Allison S	t. N.W. W	ashingt	on, D.C	. 2001	1
Baltimore,	of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	20b. Place of Disp cemetery, cre	osition (Name of ematory or other pla	ce)	Date	20c. Location	- City or Tov	vn, State
Ē	Pages tment of the tant: If the tant or old th		4 □ Donation 5 □ Other (Speci	(v)		ivet Ceme					
Bal	permit. Page Department of Important: If any Injury or once,		21. Signature of Funeral Service Lice Jee 22. Name and Address of FacilityPope Funeral Homes, P.A. 5538 Mar1boro Pike Forestville, Maryland 20747								
(a)			18/14/28/								
	Physician		Immediate Cause (Final	one cause on each line.	scleration	Cardi	01/00 00/	'an 1	CACICA		Approximate Interval Between Onset and Death
1	/Medical		disease or condition resulting in death)	- u.	consequence of):	carai	o vor cur	av ai	Jeuse		Unknown
P	Examiner		Sequentially list conditions,								
	be sit	Examiner	ri any, leading to immediate cause. Enter Underlying Cause (Disease or injury	consequence of).							
	xecut and	хаг	that initiated events resulting in death) Last	consequence of):							
68760,	icate be executed physician and s the burial-transit	alE									
_	tificati ig phy as the	fedical									
Box	th cer tendin r use	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf 1□Live birth 2		□Ectopic pregnanc	v			ate of deliver	
О	he lav requires that the death certific e has teen signed by the attending p ge 2 should be detached for use as	by Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□Pregnant at til 9□Unknown		Other (specify)			M	onth (Day Year
Records, P.O.	s that ned by		Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause giv	ven in Part I.	23e. Did t	obacco use con	tribute to the	e cause of death?
ğ	equire en sig ould b		Severe Rhea	imatoid i	21/hr, tis	, OSteo,	DOYOSIS		Yes 2□ No	3 ☐ Proba	ably 4 Unknown
00	law ri as te	Completed	Car dio me	galy, Co	onquitive	Heart	failure	24a. Was			osy findings available opposite of
	: he law care has	Con	Pleural	effusion	, Physi	ical decon	nditionin	perfo	ormed? 2 No	death?	2 □ No
Vital	siclan certifi rector	Be	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Dea				-
o	Physer this eral di	<u>۲</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatie	III 3 DOA	4 IX Nursing H	ome 5 ☐ Resident	dence 6 Dot		")
Ö	nding ath. r: Afte e fune	Certification:	Natural 5 ☐ Pending investigatio	(<i>Month, Day</i>)	Year) Injury	of 28c. Inju Wor M 1	rk? ∣Yes 2 ⊟ No		, ,		
Division or	r Atte er deg irecto	tifica	3 Suicide 6 Could not be determined		/ - At home, farm, s (Specify)	treet, factory, office		28f. Location (S	Street and Num wn. State)	ber or Rural	Route Number,
	ital o		Only of Form, Glade)								
	To the Hospital or Attending Physiclan: within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pa	Medical	29a. Certifier (Check only one) 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.								
	To th withir To th comp	Me	29b. Signature and title of certifier			29c. Licens			29d. Date signe		Day, Year)
			Chowa	lly		D4	13121		8/91	08	
R	(1)		30. Name and address of person who	com leted cause of dea	th (Item 23a) (Type	Print)	h' 10 ? /8	uxtone Ci	1:110	MD	20866
	Sta	te.	NURUL CHOW? 31. Date filed (Month, Day, Year)	confleted cause of deal of the LAY, MI, 32. Registrar	s Signature	Vino V	1100/17	RICONS	1		700-0
	Registr		AUG 1 4 2008	March 15	books						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 4:29 AM Ronald Aspinall 2008 19 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Battim land Medical Center 0+ 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 XM 2 □ F Director 262-52-7184 June 21, 1938 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show 1 XYes 2 No permit. Pages 1 and 2 should be filed within 72 hours after death with the Mar Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f sh any Injury or other traumatic event, the Medical Examiner must be notified. Director Harford Havre de Grace 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 712 Tydings Road 21078 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. N Yes 2 No If Yes, Give Year or Dates: 1 1 Never Married MY Married Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify: þ 3 Widowed 4 Divorced 1956-62 White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Production <u>Manager</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Samuel Edna Cavaliere Aspinall 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Aspinall (Wife) 712 Tydings Road, Havre de Grace, Maryland 21078 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gdns 08/22/2008 Aberdeen, Maryland 22. Name and Address of Facility Zellman Funeral Home, P.A. nathre of Funeral Service Licensee 123 S. Washington St., Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 12 hours subd /Medical Due to (or as a consequence of): Theodie W KENTAL EXAMINER Examiner Sequentially list conditions, if any, bading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Disk to for as a gensecularity of death certificate be executed burial-tran and Due to (or as a consequence of): P.O. Box 68760 ed by the attending physician detached for use as the buria Physician/Medical the IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes 2 No 25. Was case referred to medical examiner?
1 X Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 2 this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 ☐ Pending investigation 2 XNo Fall down To the Hospital or Attendl within 24 hours after death.

To the Funeral Director; A completely filled in by the fu death. 8/18/08 5:00 P 2 Accident Stops 6 Could not be determined . Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Home 712 Tyding Harre de Grace, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 204718

DHMH 17 Rev 1/2001

State

Registrar

ORIGINAL

, Baltimore MD Z1201

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

2. Registrar's Signature

Yeats,

31. Date filed (Month, Day, Year) AUG 2 7

State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Kenneth Percy Austin 6:00 a ^M July 2008 2, /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1605 Riverside Drive Salisbury Wicomico 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 1 M 2 □ F 007-03-5286 Director 96 Maine 5/6/1912 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examination and the natural and once. Maryland Wicomico 1 ☐Yes 2 No Director Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1605 Riverside Drive 21801 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Ye ar or Dates: Army Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. þ Specify: white 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) owner/operator lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Harry Winslow Austin Lena Jones 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1535 Woodland Rd., Salisbury, MD 21801 Mark D. Austin/son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/3/08 Salisbury Crematory Salisbury, MD 21. Signature of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ASCVI **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Jusacs or liqui) that initialed events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed g physician and as the burial-trans Due to (or as a consequence of): Box 68760, Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 5 ☐ Other (specify) P.0. signed d Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 icate has been si , page 2 should t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 No certificate 1 ☐ Yes 2X No Division of Vital Physician: 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 DR Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this Certification: To After the To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 TYes 2 No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my original death occurred at the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 12+1 VA 14709 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SU 21804 NATESAN 1415 5- DIVISION Vel

State Registrar 31. Date filed (Month, Day, Year)

JUL 0 8 2008

32 egistrar's Signat

2 degistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 27534 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month BROWN, Sr 6, ROBERT LEE AUGUST 2008 1650 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington Adventist Hospital Takoma Park MONTGOMERY 8. Date of Birth (Month, Day, Year) Sept. 18, 1949 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Months Days Hours Country) Virginia 1 M 2 ☐ F 214-52-5895 58 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Montgomerv Silver Spring 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14000 Castle Blvd. 20904 U.S.A. 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 Yes 2 No If Yes, Give Year or Dates: Tall Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Independent Contractor Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Walter Brown Betty Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20904 19a. Informant's Name/Relationship (Type. Print) 14000 Castle Blve, #202, Silver Spring, MD Cassandra Brown (Wife) 20b. Place of Disposition (Name of eemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Andent Crematory 8/9/08 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur of Funeral Service Lio 22. Name and Address of Facility SNOWDEN FUNERAL ROME, P.A. 246 N. Washington St, Rockville, MD 20850 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disea shock, or heart failure Immediate Cause (Final disease or condition resulting in death) LACTIC ACIDOSIS Due to (or as a consequence of): 24 HRS BOWEL ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off-Due to (or as a consequence of):

Physician /Medical Examiner

Physician

Examiner

Director

Funeral

þ

Completed

Be

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

72 hours after

d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r

permit. Pages 1 and 2 s
Department of Health as
Important: If Item 27 Is
any Injury or other trau

3altimore, Maryland 21215-0036

P.O. Box 68760

Division or Vital Records,

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/Medical

burial-transit and physician the as JSe ed by the a signed b been certificate has funeral director,

Examiner Completed Be

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Certification:

this

After

filled in by

Hospital or Attendi 24 hours after death. Funeral Director: A

24 hours a

To the ly within 24

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death.

Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4☐Pregnant at time of death

3 Ectopic pregnancy 5 ☐ Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably 4 Unknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

disease OVas Cu

24a. Was an autopsy performed? Ves 2 No

26. Place of Death (Check only one)

TAKOMA PARK MD

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 254 No

25. Was case referred to medical examiner? 1 Yes 2 No

27. Manner of Death Natural Accident 3 Suicide

5 Pending investigation 6 Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Hospital: Inpatient 2 ER/Outpatient 3 DOA Date of Injury (Month, Day Year) 28b. Time of Injury

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State) Scertifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier

4 Homicide

(Check only

29a, Certifier

and manner stated.

40064588

29d. Date signed (Month. Dav. Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ASHISH TOLIA, CARROLL 7600

State Registrar 31. Date filed (Month, Day, Year) AUG 12 2008



State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Physician Bocchino 4:10 p M Julia Ciccotti August 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 14400 Homecrest Road, Silver Spring Montgomery 8. Date of Birth (Month, Day, Year) If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🔀 F Director 198-14-3280 97 Nov. 18, 1910 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 ☐ Yes 2 1 No Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with 14400 Homecrest Road, #125 20906 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 72 hours after 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 🛣 No Specify: Specify: White <u>≨</u> 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Heatth and Mental Himportant: If Item 27 Is marked oth any injury or other traumatic event Be Domenic Ciccotti Margaret Acri ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marian B. McClafferty/Daughter 1318 Hemlock Street, NW, Washington, DC 20012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 X Removal from State August 2008 14 Cathedral Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Scranton, PA 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signal of Funeral Service Licenses 500 University Blvd.. W., Silver Spring. MD 20 Approximate Interval Between Onset and Death ru and 2 MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) Failure To Thrive /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any locality immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last General Debility ner Due to for as a consequence of certificate be executed Exami sician and burial-trans Due to (or as a consequence of) physician the burial Box 68760 Physician/Medical attending p 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? ned by the atter e detached for u 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) □Yes 2□No P.O. 9 Unknown 9 I Inknown signed by The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, pe 2 Hypertension, Diabetes Mellitus, Bronchial Asthma 1 ☐ Yes 2 【X No 3 ☐ Probably 4 ☐ Unknown should I Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? certificate 1 ∐Yes 2**x** No 1 ☐ Yes 2 ☐ No e Hospital or Attending Physician: 24 hours after death.
9 Funeral Director: After this certificalety filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ၉ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c, License number D23170 August 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Gita Bakshi, MD 9406 Old Georgetown Road, Bethesda, MD 20814 31. Date filed (Month, Day, Year) AUG 12 32: Registrar's Signature State 1 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year August 8, 2008 2:05pM Edward Brown. Sr. Leroy 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Clinton Nursing Home & Rehab. Clinton Prince Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, une 10, 9, Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Days Months Hours Min. 1 M 2 □ F Washington, D.C. 1950 578-66-7147 58 June Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b County 1 ZYes 2 No Ft. Washington Maryland Prince Georges 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 United States 12015 Hickory Dr. 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 □Yes 25€ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 No Specify: Black 1 □ Yes 2√□ No Specify: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Washington Post Mailer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy Lewis Edward H. Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 10300 Nareen St. Upper Marlboro, Md. Mary E. Brown / Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/15/2008 Suitland, Md. Lincoln Cemetery 21. Signatur f Funeral Service Licer ee 22. Name and Address of Facility Alexander S. 5538 Mariboro Pope / Porestville, Md. 20747 MO1083 Approximate Interval Between Onset and Death 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Jnknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed'

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

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28a-f

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination must be notified at

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 Is marked other than any injury or other traumatic event, Ite Me

72 hours after

Baltimore, Maryland 21215-0036

Box 68760,

P.O. I

Division of Vital Records,

certificate be

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use as the burial-trans and physician for the detached signed by the certificate has page 2 I or Attending Physician: after death.
Director: After this certifica director. funeral (the 1

Examiner Physician/Medical à Completed Be Certification: To

filled in by To the Hospital o within 24 hours aff To the Funeral Di completely filled in

State Registrar

Medical

Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ♣No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

+ WASHIND

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JAnna illiaT

11701

31. Date filed (Month, Day, Year) AUG 1 4 2008

(Check only one)

29b. Signature and title of certifier

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 08, 01:00A AUGUST 2008 BOYD /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ST. MARY'S ST. MARY'S HOSPITAL LEONARDTOWN If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth **Funeral** 1 M 2 X F 2/16/1923 85 Fayetteville, TN Director 412-20-5704 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at txTYes 2 No Director Upper Marlboro Maryland Prince george's the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 2 11110 Pompey Drive United States 20772 Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23. Funeral ıral", or items 2 i Examiner mu 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Black 2 3X Widowed 4 ☐ Divorced Year or Dates: er than "natur , the Medical B Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Domestic Housewife 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 Mattie Benton Hollis Dyer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11110 Pompey Drive Upper Marlboro, Maryland 20772 Shirley Machonis_/_Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of I Important: If ite any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery 8/16/2008 Clinton, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Liq 22. Name and Address of Facility Pope Funeral Home, P.A. 5538 Marlboro Pike Forestville, Maryland 20747 Approximate Interval Between Onset and Death Part / Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician reonT /Medical Due to (or as a consequence Examiner Nothermia Sequentially list conditions Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed Sep55 physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical as attending p IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☒ No 24a. Was an has s certificate has lirector, page 2 autopsy performed 2 No 2 🔀 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 27. Mannér of Death 28d. Describe how injury occurred 28c. Injury at Work? After 5 Pending investigation 1 Natural (Month, Day Year) Injury 1 ☐ Yes 2 ☐ No s after death.

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od in by the fu 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide within 24 hours a

To the Funeral I

completely filled 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and the of certific 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who com BHRDAD 31. Date filed (Month, Day, Year) 32. Registrar's Sign State AUG 1 4 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav Year Month **Physician** 8:10 p.m. 2008 Mildred Brown August 16. Alice /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 44444 Richey Road Leonardtown St. Mary's If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday **Funeral** Days 1 M 2 XF Director 213-38-3140 99 11/09/1908 Maryland Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show ir than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2X No Director Maryland St. Mary's Leonardtown the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with <u>United States</u> Funeral 44444 Richey Road 20650 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 □ Yes 2 🛣 No Specify: Specify: þ 3 X Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other than 'ury or other traumatic event, the Ment of the traumatic event, the Ment of the traumatic event, the Ment traumatic event traumatic event, the Ment traumatic event event event event traumatic event Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) æ ပ James Rebham Lilly Mae Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If item 27 is any injury or other trau once. Lloyd E. Brown, Jr./Son 44444 Richey Road, Leonardtown, Maryland 20650 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. George's
Episcopal Cemetery 20c. Location - City or Town, State 20a. Method of Disposition Date 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08/21/2008 Valley Lee, Maryland 22. Name and Address of Facility Brinsfield Funeral Home, P.A. ral Service Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 20650 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nset and Dea Immediate Cause (Final disease or condition resulting in death) Dement's **Physician** /Medical Due to (or as a consequence of): Examiner Hylatensio? Sequentially list conditions, if an, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed and burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year 5 Other (specify) ☐Yes 2☐No ned by the a 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ 2 No 3 Probably 4 ☐ Unknown 1 ☐ Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐Yes 2 ☐ No Hospital or Attending Physician: ours after death.

eral Director; After this certific filled in by the funeral director, 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☑ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. May er of Death 28b. Time of 28a. Date of Injury 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours 29a. Certifier 🛮 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 2213 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Suresh Patel, M.D. 22650 Cedar Lane Court, Leonardtown, Maryland 20650 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar **AUG 19**

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lidury or other traumatic event, i'lle Modral Examinational Londing at 2008e. Physician /Medical

Baltimore, Maryland 21215-0036

Examiner tal or Attending Physician: The law requires that the death certificate be executed rs after death.

al Director: After this certificate has been signed by the attending physician and ed in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

To the Hospit within 24 hour To the Funer completely fill	Medical
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Sta Registr	

1 - State Registrar Certificate of Death Reg. No.											
	1. Decedent's Name (First, Middle, Last)			2. Date of Month		Day Year	3. Time of Death				
an cal	Lottie G. Bennett			Augus			6:34 P_M				
ner	4a. Facility Name (If not institution, give street and number)	4b. City, To	wn, or Location o			4c. County of Deat	h				
	Washington Adventist Hospital	Tako	ma Park			Montgom					
	5. Social Security Number 6. Sex 7. Age (In yrs. last be	irthday) If Under 1 Months I	Year If Under 2 Days Hours	24 Hrs. 8. Date of Min. (Month	Birth Day, Yea		hplace (State or Foreign				
	250-10-8025	Yrs.	, iou.o	Oct 1			th Carolina				
	Usual Residence of Decedent						10d Inside City Limits				
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당	District of Columbia W	<u>Vashington</u>									
Director	10e. Street and Number	10f. Zip C			10g.	Citizen of What Co	ountry?				
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Completed	15. Decedent's Education (Specify only highest grade completed)	a. Decedent's Usual (Give kind of work life. DO NOT use	Occupation do <i>ne during m</i> ost	t of working	16b	. Kind of Business	Industry				
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		b. Mailing Address (
	Leroy P. Hardy, Jr 2nd Cousin I				_						
	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State	of Disposition (Name ery, crematory or oth		Date		. Location - City or	rown, State				
	4 □ Donation 5 □ Other (Specify) Lee	s Cremato		ig 12, 200		Clinton,					
	21. Signature of Funeral Service Hoensee			y Stewart			-				
	MITTER OF HUNG!			Road, NE V			C 20019				
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	resulting in death) Due to (or as a consequence						11-				
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Examiner	that initiated events		was	₹							
ĕ	resulting in death) Last Due to (or as a consequence	e of):									
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atio	1 ☑ Natural 5 ☐ Pending (Month, Day, Year) 2 ☐ Accident investigation	М	1 ☐ Yes 2 ☐	No							
liji	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, building, etc. (Specify)	farm, street, factory,	office	28f. Locati	on (Stree Town, S	t and Number or F	ural Route Number,				
le le	January, etc. (2725)			0, 0	701111, 0						
29a. Certifier (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
Medical Certification:	one) and manner stated.	and of miveougation, i	y opinion, dea	ooodii ed at tile t	_						
Σ	29b Signature and title of certifier	29c.	License number	0-0		Date signed (Mon					
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	Name and address of person who completed cause of death (Item 23a		P		1		n a naero				
	AHMED NAWAZ POBO	X 8381	9 90	auhers	ou	gril	020883.				
ate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	-									
rar	AUG 1 2 2008 Keeper & 65	ME!									

		1 - State Registrar		C	ertificate of	Death	Re	eg. No2 0	08	27540
Physicia	an	1. Decedent's Name (First, Middle, L	.ast)				Date of Death Month	Day	Year	3. Time of Death
/Medic	_	VIERA R. BUNCE					AUGUST		2008	12:35AM [™]
Examin	er	4a. Facility Name (If not institution, g				or Location of Deat	h		y of Death	r
		WILLIAM HILL MA 5. Social Security Number 6.		(In yrs. last birthda		ASTON If Under 24 Hrs	8. Date of Birth		CALBO	lace (State or Foreign
Funeral Director		174-48-6372 Usual Residence of Decedent	1 M 2 X F	100 Yrs	Months Days				Cour	SACHUSETTS
/land ow		10a. State 10b. County		10c. City, Town or	Location				1	0d. Inside City Limits
Mary fied	ģ	MD TALBO	OT	EAS	TON					1 ☐ Yes 2 ☐ No
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r dea	nue	11. Marital Status	12. Was Decedent Example 12. Was Decedent Exam	ver in U.S. 1	Was Decedent of I If Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puer	pecify Yes or No- to Rican, etc.)		ce - Americ	
s afte	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give		1 ☐ Yes X ☐ No			Speci	ty: WH	(TE
ges 1 and 2 should be filed within 72 hours after death with the Maryland not Heatih and Mental Hygiene. If flem 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		15. Decedent's	Year or Dates:	16a De	cedent's Usual Occu	pation	1	16b. Kind of E	Business/Inc	dustry
in 72 n "na Medic	Completed	(Specify only highest g	rade completed)	(G	ive kind of work done e. DO NOT use retire	during most of wo	rking		, ao	
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al Hyg othe vent,	Be C	17. Father's Name (First, Middle, La.	st)			18. Mother's Na	me (First, Middle, N	faiden Surna	me)	
Ments Ments arked	٩	CALVIN B. ROBBIN	NS			MAY V	TERA			
2 sho and Is ma		19a. Informant's Name/Relationship	(Type. Print)	19b. Ma	ailing Address (Street	t and Number or R	ural Route Number,	City or Town	n, State, Zip	Code)
and lealth m 27 her tr		STEPHEN C. BUNCE	E/SON		BOX 236,	NASSAWAD				
Pages 1 nent of H int: If ite iry or ot		20a. Method of Disposition 1 Burial 2 □ Cremation 3	☐Removal from State	cemetery, o	sposition (Name of rematory or other pla	ice)	Date 2	20c. Location	- City or To	wn, State
t. Pa tmen tant: jury		4 □ Donation 5 □ Other (Spec		WOODLAW	N MEMORIA		/8/2008	EASTO	N, MAI	RYLAND
permit. Pages 1 and 2 Department of Health Important: If Item 27 I any Injury or other tro		21. Signature of Funeral Service Lic	ensee		22. Name and Addre		N & NEWNA	AM FUN	ERAL I	HOME PA
		23a. Prt1. Enter the disease, or co	molications that caused t		200 S. HAI	RRISON ST	., EASTO	MD.	21601	
		hock, or heart failure. List on Immediate Cause (Final	ly one cause on each line	e.		illy, such as cardia	c or respiratory arre	351,		Approximate Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a	Jeu	te lexi	run			_	ZWELL
Examiner			Due to (or as a	consequence of):	house	In Die	Letus			Lan
14	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a	consequence of).	300					7
outed d ansit	Examiner	dany, leaving to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events	C							
an an rial-tr		resulting in death) Last	Due to (or as a	consequence of):						
icate be executed physician and s the burial-transit	Medical	•	d							
ng as	Med	IF FEMALE:					-135			
eath ce attendi for use	ian/	23b. Was decedent pregnant in the past 12 poinths?	23c. If yes, outcome p	Fetal death	3 □Ectopic pregnanc	у			ate of delive	ery Day Year
the a	Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4□ Pregnant at t 9□ Unknown	ime of death	5 ☐ Other (specify) _					July 100.
w requires that the deben signed by the should be detached		Part II. Other significant conditions	contributing to death but	not resulting in the	undedvina cause ai	ven in Part I.	23e. Did tob	acco use cor	ntribute to th	ne cause of death?
uires sign d be	d by	Herrensi	ue Carles	usalar	Lescon		1 □ Ye	s 2⊒No	3 ☐ Prob	nabiy 4 ∐Unknown
w req	Completed	Dare Dage	al Carinel	Harrien	bumboo	seal sa	-	245	Woro auto	and findings available
he lav e has ige 2 :	m	MOI D.	1000 0	thouse	- mg 11000 s	avat sym	autops perforn	y /	prior to co death?	psy findings available mpletion of cause of
ificate or, pa		25. Was case referred to medical	Jacks 2	2000		00 Dian -4 D-		2∕□ No	1 🗌 Yes	2 No
/sicle	o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	t 2 ER/Outpat	ient 3 DOA Oti	nor:	ath <i>(Check only one</i> Iome 5 ☐ Reside		thor (Cassit	5.1
g Phy er thi	\vdash	27. Manuer of Death	28a. Date of Injury (Month, Day	28b. Time	e of 28c, Inju		28d. Describe ho			<i>y)</i>
ath. rr: Aff	Certification:	1 ∠Natural 5 ☐ Pending 2 ☐ Accident investigati		Year) Injur		rk?]Yes 2 □ No				
r Atte er dea recto by th	iii	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		y - At home, farm,	street, factory, office		28f. Location (Str. City or Town		ber or Rura	I Route Number,
Ital or saft ral DI led in	Se									
Hosp 4 hou Fune tely fil		(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of a	examination and/o	eath occurred at the trinvestigation, in my	ime, date and plac opinion, death occ	e, and due to the ca urred at the time. de	ause(s) and nate and place	nanner as s	tated. the cause(s)
ro the Posthin 24	Medical	one)	and manner stat	ed.						
T Will		29b. Signature and title of certifier	Ma)	nalla	29c. Licen	0 (2°7), "	- 29	9d. Date sign	eu (Month,	vay, rear)
TLS		r vee	uem 11 0	year ji	11) 4	00/12		0/-	108	
10		30. Name and address of person wh WILLIAM H. WOOI				EASTON,	MARYLANI	2160	1	
Sta Registra		31. Date filed (Month, Day, Year) AUG 0 6	32_Registrar		hade	<i>.</i>				
negistr		7,74 7 7 7		/						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year 1620 2008 MABLE I. BENES August 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Talbot Hospital Easton EASTON Memorial If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) OCT 1, 1920 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days 1 □ M 2 🛛 F WEST VIRGINIA 87 236-22-8860 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 1 XYes 2 □ No RIDGELY CAROLINE MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21660 USA 204 PARK AVE. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify Specify: WHITE 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) GAS & ELECTRIC CO. CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) **NELLIE GRAHAM** WOODROF IGO 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 204 PARK AVE., RIDGELY, MD 21660 MARTHA C. BENES/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 8/10/2008 STEVENSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate Immediate Cause (Final) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) SEPS1 Due to or as a contequence of) Sequentially list conditions if any, Isaaing to in media cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Romal

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funeral

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Completed

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d other than "natural", or items 23a or 28a-f showevent, the Medical Examiner must be notified at

is marked other

Department of Health Important: If item 27 any Injury or other to once.

I and 2 should be filed within 72 hours after death with the Maryland

Maryland 21215-0036

Baltimore,

Pages 1

Examiner sician and burial-trans page 2

attending physician for use as the buria nas

requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

the Hospital or Attending Physician: ithin 24 hours after death.

the Funeral Director: A within 2 To the I TLS 5 State

dical	La Acute Kenal failure													
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No												
þ	Part II. Other significant conditions con	rition	sulting in the underlyli	23e. Did tobac	cco use contribute to the cause of death?									
Completed	Anem	la		•	24a. Was an autopsy performe	24b. Were autopsy findings available prior to completion of cause of death? No 1 □ Yes 2 □ No								
Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient 2	€ER/Outpatient 3 □	Othor:	Death (Check only one) Home 5 Residence	te 6 ☐ Other (Specify)								
ation: 1	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how	injury occurred								
Certification: To	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, facify)	ctory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)									
Medical (se(s) and manner as stated. e and place, and due to the cause(s)								
Š	29b. Signature and title of certifier	+		29c. License number	29d	. Date signed (Month, Day, Year)								

DHMH 17 Rev 1/2001

Registrar

Memorial Hospita

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OKUNDO

31. Date filed (Month, Day,

bayom1

& 19b amend lines 10e & 12 per fd Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. aaco hlth dept 08/21/08 dlw State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** Aug 2008 James Leonard Besley, III /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Washington County Health System Hagerstown If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Funeral 1**XX**M 2□ F Director 577-44-2521 1934 Washington, DC Feb. 10, Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exercites roust be notified at 1 ☐ Yes 2 ▼ No Director Maryland Washington **Keedysville** 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 2 Audubon Way 21756 USA 2 Audobon Way Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1952. 1 Zyes 25 Ne 1956 1 Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No <u>چ</u> 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 Elementary/Secondary (0-12) College (1-4or 5+) IBM Computer Technician 12 should be filed w h and Mental Hygie 7 is marked other th 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pearl Lorraine Chapple James Leonard Besley 19**5 Mailth Address (Street** and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any Injury or other trau Mary L. Besley/ Wife |2 Audobon Way Keedysville, MD 21756 20b. Place of Disposition (Name of cemetery, crematory or other place)
Maryland 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Veterans Cemetery 8/18/2000 Concerns

22. Name and Address of Facility Robert E. Evans Funeral Home 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Jet likin 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** worumonary hr /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and Box 68760, physician the death certificate be Physician/Medical the as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No P.O. the 9 Unknown þ Part !!. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s has autopsy certificate 1 ☐ Yes 2 No of Vital Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ this After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division l XVatural 5 Pending investigation in 24 hours area the Funeral Director: Af 1 □Yes 2 □ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical within 24 ho

To the Fune

completely (Check only one) and manner stated. 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) D 44996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Zafar Malik MD 20311 Cappans Rd Boons50

State Registrar 2. Registrar's Signature

			1 - For State Registrar	State of N	Maryland	/ Depa	irtment of H	ealth ai Death	nd Mei		iene	800	27543
		.e., -	1. Decedent's Name (First, Middle, La	ist)					2.	Date of Deat Month	h Day	Year	3. Time of Death
E	Physici /Medic		William	Т.			Bendix			8	9	2008	3:28 PM
	Examir		4a. Facility Name (If not institution, gir	ve street and numbe	or)		4b. City, Town, or	Location of	Death		4c. Cou	nty of Death	
	₹ ************************************	10	711 Edgar Drive				Salisb				Wice	omico	
100	Funeral			Sex 7 1⊠M 2□F	Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hours	Min.	Date of Birth (Month, Day,	Day, Year) Country)		
9 -	Director		214-66-7500	TAN EUT	52	Yrs.			3	3-23-19	56	Mary	land
	and w	1	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	fown or Lo	cation						10d. Inside City Limits
	f aho	ō	MD Wicomi	0.0	Co.1	ichu	C17						1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number	.00	Sal	Lisbu	10f. Zip Code			1	Og. Citizen	of What Cou	intry?
	with be or	0						1007					,
	heath	Funeral	711 Edgar Drive	12. Was Decede	nt Ever in U.S.	13. \		1804 spanic Origi	in? (Specif	v Yes or No-	US.	Race - Ameri	ican Indian,
10	the r	핕	1 Never Married 2 Married	Armed Force 1 ☐ Yes 2 [s?		Vas Decedent of His Yes, specify Cubai	n, Mexican,	Puerto Rio	can, etc.)	E	Black, White,	, etc.
036	urs a	by	3 ☐ Widowed 4 🏋 Divorced	If Yes, Give Year or Date.	-		I□Yes 2X No	Specify:			Spe	ecity: Wh	nite
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21	within 7 ene. than "r	ple	(Specify only highest gi	College (1-4c	or 5+)	life.	DO NOT use retired,)	or working				
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nd	be file tal Hy d oth	Be (17. Father's Name (First, Middle, Las	t)				18. Mother	's Name (F	First, Middle, I	Maiden Sun	name)	
<u>yla</u>	should and Meni	ပ	Robert	J.	Ber	ndix		Barl	bara			MacMi	.11an
Maryland			19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ig Address (Street a	nd Number	or Rural A	Route Number	City or To	wn, State, Zi	p Code)
	permit. Peges 1 and 2 Department of Health s Important: If Item 27 It any Injury or other tra <u>once</u> .		Robert J. Bendix	- Father			Edgar Dri	ve, Sa					
Baltimore,	ot H		20a. Method of Disposition 1 Burial 2 □ Cremation 3 (Removal from Sta	com	e of Dispo letery, crei	sition (Name of natory or other place	9)	Date	Э	20c. Location	on - City or T	own, State
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ait	permit. Departr Importe eny Inju		21. Signature of Funeral Service Lice	ensee		22	. Name and Addres	s of Facility	Boun	ds Fun	eral	Home	
111	20229		Denes 12	lly tours	ω	7	05 E. Mai	n Str	eet,	Salisb	ury,	Maryla	ınd 21804
-			23a. Part 1. Enter the disease, or con shock, or heart failure. List only	nplications that caus y one cause on each	sed the death. I	Do not ent	er the mode of dying	g, such as c	ardiac or re	espiratory arr	est,		Approximate Interval Between
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	/Medical		resulting in death)	Due to (o	as a consequer	nce of):		<i>^</i> .					
	Examiner		Sequentially list conditions	b. 76	rastation		lastric	CAVCI	nomo				
	D =	lner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consequer	nce of):							
	and trans	Examlner	Cause (Disease or injury that initiated events resulting in death) Last	c									
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to	Physician: this certific ral director,	²	1 Yes 2 No	1 L Inpa		VOutpatier		4	sing Home	_		Other (Spec	ufy)
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Š	or A after Dirac	artif	4 Homicide determine	building,	etc. (Specify)	e, tariis, sti	eet, factory, office		20	City or Tow		umber or Au	rai noute Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a, Certifier 17 Certifying P	hyeician: To the he	et of my knowle	adaa daat		a data and	d along on	el elup an abou m	2(2) 22.		atatad
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10	" (3) (4) (4)	ate	31. Date filed (Month, Day, Year)	3 Req	istrar's Signatur	0 4	77 · O/ OL	ALTE F	1 / 3		INID	0100	3
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08-06069 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Jennifer A. Hamill-Bradley State of Maryland / Department of Health and Mental Hygiene 2008 27545 Certificate of Death Reg. No Registrar 2. Date of Death Time of Death 1. Decedent's Name (First, Middle.Last) Physician/ 1758 hrs Bradley - Hamill Jennifer Alyn August 8, 2008 **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Wicomico Rerlin #5 High Sheriff Trail 9. Birthplace (State or Foreign If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYY) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Country) Days Hours Min Months Director M 2 X F 221-70-5250 Yrs 03/07/1973 35 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 XYes 2 No 28a-f show notified at once. Maryland Worcester Berlin with the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number #5 HighSheriff Trail 21811 USA 23a or Funeral 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) must be death Armed Forces' 1 Never Married 2 Married Yes white 4 X Divorced Yes, Give Year Yes 2 X No specify: Specify: 3 Widowed Pages 1 and 2 should be filted within 72 hours after neut of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or other traumatic event, the Medical Examiner. þ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+ 2 pre school teacher 5-0036 12 education 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2121 Karen Baker Alan R. Bradley Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2 5545 Broad Dr., Laurel, DE 19956 Alan R. Bradley/father 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 8/11/08 Riverton, MD ant: Riverton Cemetery ment Donation 5 Other Specify 21. Signature of Funeral Service Lice see 22. Morroway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part I. Enter the disease, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line. /Medical Death a Acute & Chronic Subdural Hemorrhage Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed Physician/Medical #1 per ME g882 8/27/08 TT X UNPENDED X AMENDED attending physician or use as the burial 23a, PII, 27, 28a-f, perME, G883, 9/5/08 TI Records, P.O. Box 68760 23d. Date of delivery IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year Month Dav Live birth 3 Ectopic pregnancy Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 ✔ Unknown has been signed by the att 2 should be detached for g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably 4 Unknown Chronic Alcoholism Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy certificate has b ector, page 2 sh death? performed' No ✓ Yes 2 ✓ Yes 26. Place of Death (Check only one) Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be examiner? |Hospital: 1 | Inpatient 2 Other₄ Residence 6 V Other: Scene DOA Nursing Home 5 ER/Outpatient 3 this 1 Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural n 24 hours after death.

e Funeral Director: A letely filled in by the fu Yes 2 X No 5 Pending Fnd 8/8/08 Fnd 5:50pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5 High Sheriff Trail 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 6X Could not be Suicide or Town, State) 5 Berlin, MD unk determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

within 2 To the 1

2008

29c. License number

OCME.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 9, 2008

State

Registrar

29b. Signature and title of certifier

AUG 2

Ana Rubio MD. 31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Ballard Isabello XILO 2008 Jul /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Medical Center Wicomics Peninsula Regional If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Year) Days 1□M 2☑F Months 216-44-8714 412911941 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumetic event, the Medical Examiner must be notified at 1 ☐Yes 2 🗹 No **Funeral Director** MD inces 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2185 Buller 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?/ 1 ☐ Yes 2 ☑ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 hours after 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑
If Yes, Give
Year or Dates: Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify à Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) University and 2 sho Id be filed within leasth and ental Hygiene. and I ental Hygiene. is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Maryland Eastern Shore 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ballard ecie Handy ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a avonn Baile Vane Princessanne HD Sherree 20b. Place of Disposition (Name of cemetery, crematory or other place, Pages 1 20a. Method of Disposition 20c. Location - City or Town, State Department of Important: If it any Injury or o once. 1 ☑ Burial 2 ☐ Cremation Olive Baptist 7126108 Dublin, MD 4 ☐ Donation 5 ☐ Other (Specify) 21 Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St. Bennie Snith Funcial Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ongat disease or condition resulting in death) 4841 /Medical Due to (or as a consequence of): Examiner CAP Sequentially list conditions, if any, leading to immediate cause. Errier underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 5 Other (specify) 1 ☐Yes 2 ZNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 □ Yes 2 1 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1941721 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PANLOS 21804 STEPMAN 400 E. SHORE DR SALISBURY 31. Date filed (Month, Day, Year) mo 32. Registrar's Signature

DHMH 17 Rev 1/2001

Registrar

JUL 23

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2008 **Physician** Robert J. Crosson, Sr. A^{M} August 8, 2:45 /Medical 4a. Facility Name (If not institution, give street and number) 4h. City. Town, or Location of Death 4c. County of Death Examiner Gaithersburg Wilson Health Care Center Montgomery If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min 1 X M 2 □ F 284-12-8153 Director 87 Jan. 2, 1921 Ohio Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "nature!" any injury or other traumatic excessions. 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location Maryland Montgomery Montgomery Village 1 ☐ Yes 21KiNo Directo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 19117 Roman Way 20886 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status 1 Never Married 2 Married 1 □Yes 21 No Specify: White If Yes, Give Year or Dates: WW II Specify: δ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. of Energy Nuclear Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marie Urban ပ္ John Crosson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert J. Crosson, Jr. 20886 20813 Aspenwood Lane Montgomery Village, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 Removal from State August Metropolitan Crematory Alexandria, VA. 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility DeVol Funeral Home Signature of Funeral Service License 10 East Deer Park Drive Gaithersburg, MD. 20877 Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Years Lymphoma /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed the burial-trar that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending p IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has b 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 ∐Yes 2 XNo funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Medical Certification: To 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 ☐ Pending investigation s after death.

I Director: Af id in by the fur 1 ☐Yes 2 ☐ No 2 ☐ Accident 6 ☐Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide To the Hospital o within 24 hours af To the Funeral DI completely filled in 29a. Certifier 1 🖾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D20148 August 08, 2008 104 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven Dolinsky, M.D., 911 Russell Avenue, Gaithersburg, MD. 20877 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 12 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:15 P M AUGUST 2008 CARTER RONALD /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner MONTGOMERY Collingwood Rehab & Nursing Ct Rockville If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours Min. 1 **∑**tM 2 □ F 217-44-7677 Mar. 25, 1947 Maryland Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show 10a. State 10b. County s 1 and 2 should be filed within 72 hours after death with the Marylai of Health and Mental Hygiene.
item 27 is marked other than "natural", or Items 23a or 28a-f shov other traumatic event, if a Marylaid Examiner minist to a refified at Yes 2 □ No Rockville MD Montgomery Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20850 U.S.A. 710 N. Stonestreet Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Never Married 2 🙀 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Black Specify: ò Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15 Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Self-employed llth 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ella Cooper Melvin Carter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 710 N. Stonestreet Ave., Rockville, MD 20850 Jean Carter (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If ite
any Injury or ot ₩SBurial 2 ☐ Cremation 3 ☐ Removal from State Norbeck Mem. Park 8/16/08 Olney, MD 5 ☐ Other (Specify) 22. Name and Address of Facility SNOWDEN FUNERAL HOME, P.A. 21. Signature of Funeral Service Lice 246 N. Washington St, Rockville, MD 20850 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) /sician and certificate be executed Exami Due to (or as a consequence of) physician the burial P.O. Box 68760 Physician/Medical attending p as IF FEMALE: use 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) signed by the a d be detached for ☐Yes 2☐No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 ☐ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b Time of 28c. Injury at 28d. Describe how injury occurred Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie 00062435 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850/SAYED EISAYYA! Male Colar LOC 10110 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 12 AUG 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylan		rtificate of			eg. No. 20	08	27549
	Physici		1. Decedent's Name (First, Middle, La	st) ELIZABETH CA	NNON			2. Date of Dear	r Day, 20) ₀ 8	3. Time of Death 2013 M
	/Medic Examin		4a. Facility Name (If not institution, given Washington A		pital		r Location of Death	1	4c. County of MONTO		RY
	Funeral Director		5. Social Security Number 6. 5 7 9 - 5 8 - 4 5 9 3	Sex 7. Age (In vrs.		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Apr. 2	,1945	9. Birthp	lace (State or Foreign
	yland how at		Usual Residence of Decedent 10a. State 10b. County		ty, Town or Lo					1	0d. Inside City Limits
	the Mar 28a-f sl	ector	MD Prince	Geo	Suitl	10f. Zip Code		1	0g. Citizen of W	hat Coun	1 AYes 2 No
	23a or	al Dir	5619 Regency	Park Court	#10		746			5 . A .	
936	nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland artment of Health and Mental Hyglene. ortant: If item 27 Is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at B.	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 2 No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2점 No		pecify Yes or No- to Rican, etc.)	Black	- Americ K, White, Bla	
15-0	"natur	leted	15. Decedent's E (Specify only highest gr	ducation ade completed)	16a. Dece	dent's Usual Occup kind of work done DO NOT use retired	oation during most of wo	rking	16b. Kind of Bu	siness/Ind	dustry
2121	filed withir Hygiene. other than ent, the Me	omo	Elementary/Secondary (0-12)	College (1-4or 5+)		ete ria M			D,C,	Pub1	ic School
and	l be file ntal Hy ed othe event,	Be	17. Father's Name (First, Middle, Last Russell C. D	,				me (First, Middle, . erta Wi		e)	
Maryland 21215-0036	2 should be fi and Mental H Is marked ot aumatic ever	T ₀	19a. Informant's Name/Relationship	(Type. Print)		ng Address (Street	and Number or R	ural Route Numbe	r, City or Town,		
	Health tem 27 l		Jewell Johns 20a. Method of Disposition			9 Reger		Ct, S	uitland		
mor	Pages lent of I nt: If ite		1 ☐ Burial 2 【Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci			osition (Name of matory or other plan Cremato			Hanov	,	
Baltimore,	permit. Pages 1 Department of h Important: If ite any Injury or ot		21. Signature of Funeral Service Live		2	2. Name and Addre	ss of Facility S1	NOWDEN			ME, P.A.
	403.60		23a. Parti Enter the disease, or con shock, or heart fajlure. List only	notications that caused the dear						re, M	Approximate Interval Between
ě.	Physician		Immediate Cause (Final disease or condition	A	MYO		KA	FARC	TEON		Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec	quence of):	o. Re	entr	DIE	EASE	-	
Į.	/s #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consec	quence of):	A/6					
D	execute n and al-trans	Examiner	that initiated events resulting in death) Last	c. Due to (or as a consec	quence of):	> Ive	The same	us			
68760,	tificate be executed ig physician and as the burial-transit	ledical		o. Hyle	Utt	~5I	2				
.O. Box 6	ath cer ttendin or use	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome pf pregn 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of o	al death 3[⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у		23d. Dat		ery Day Year
Ω.	res that the de signed by the a be detached t	by Ph	Part II. Other significant conditions	contributing to death but not res	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	bacco use conti	ibute to t	he cause of death?
Records,	w require been signation	eted t							′es 2 No		
Rec	The law	Completed						24a. Was a autop perfor	rmed r	prior to co death?	ppsy findings available impletion of cause of
Vital		BeC	25. Was case referred to medical examiner?					1 Yes ath <i>(Check only</i> o		I∐Yes	2 140
ō	gi is	2	1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatie	IL SELDON		Home 5 Resid	lence 6 Oth		fy)
sion	Attending F r death. ector: After by the funera	ation	1 ☐ Natural 5 ☐ Pending investigation	(Month, Day Year)	Injury	Wo	rk?]Yes 2∐No				
Division	l or Att after de Directe I in by t	Certification:	3 Suicide 6 Could not I 4 Homicide determined		iome, farm, st ify)	reet, factory, office		28f. Location (S City or Tow		er or Run	al Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical Ce		hysician: To the best of my kn miner: On the basis of examin and manner stated.							
	To th To th comp	Me	29b. Signature and title of certifier	3 11	\	29c. Licens	se number		29d. Date signer	d (Month,	Day, Year)
	5		30 Name and address of person wh	completed cause of death (Ite	m 23a) (Tupo	Print)	And	OT	08	1. C.	6/08
			and address of person wa	-choce A	TAN	4115	TAV	- AAAA	Dit	1/	

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State

31. Date filed (Month, Day, Year) AUG 12 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death CICERO Month **Physician** Year OY UCILLE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's 12803 Kendale Lane Bowie If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 212-05-1072 1 □ M 96 Director May 12,1912 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Prince George's 1 □Yes 2 No Director Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12803 Kendale Lane 20715 USA Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: 3 Widowed 4 □ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frank Rapisarda Vincenzina Spampinato 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joan A. Hamilton/Daughter 1717 Urby Drive, Crofton, Maryland 21114 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ■Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery 8/14/2008 | Bowie, Maryland 22. Name and Address of Facility 21. Signature of F Beall Funeral Home 6512 NW Crain Highway, Bowie, Maryland 20715 23a. Part1. Enter the disease, shock, or heart failure. L death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine the Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? certificate 1∏ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 1 | Yes 2 | No ٩ 4 Nursing Home 5 DAResidence 6 □Other (Specify) After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of centifier 29d Date signed (Month, Dav. Year) Name and address of person no completed cause of death (Item 234) (Type, Print) 11 HATELJ. La Y41 31. Date filed (Month, Day, 32. Registrar's Signa State AUG 1 4 2008

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 8:40 p.m. Antonio Castillo August 16, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Nursing Center Leonardtown St. Mary s

9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 5. Social Security Number 6. Sex 1 X M 2 ☐ F Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Director 577-52-3635 09/20/1937 Puerto Rico Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10b. County 1X Yes 2 No Directo Maryland | St. Mary's Leonardtown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 21585 Peabody Street United States 20650 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 🕅 No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 X Yes 2 ☐ No Specify. ģ 3 Widowed 4 Divorced Puerto Rican White Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Ith and Mental Hygiene. 27 is marked other than 'r traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Never Worked 11 Never Worked 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Luis Antonio Castillo Elsa Monserrate Morales Department of Health and Important: If Item 27 is many injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elaine Ohler/Sister 39425 Thomas Drive, Mechanicsville, MD 20650 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 08/20/2008 | Suitland, Maryland Cedar Hill Cemetery 22. Name and Address of Facility Brinsfield Funeral Home, P.A. Edward N. Brinsfield, Jr. M00052 22955 Hollywood Road, Leonardtown, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician minutes /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed and burial-trar Due to (or as a consequence of): Box 68760. ding physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant atten for u 3 □Ectopic pregnancy 4 Pregnant at time of death 9 Unknown in the past 12 months? Month Year 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No 9 ☐ Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? or Vital Records, 9 1 ☐ Yes 2 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed? certificate 2 P No 1 ☐ Yes 2□ No 25. Was case referred meaniner? Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 200No 1 Inpatient 2 ER/Outpatient 3 DOA P funeral (nours after death.

Ineral Director: After the filled in by the funeral 27. Manner of Death 28a Date of Injury 28b Time of 28d. Describe how injury occurred Certification: Division (Month, Day Year) or Attending 5 Pending investigation 1 Natural 1 Yes 2 No 2 ☐ Accident 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannet stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James P. Jarboe, M.D 4035 Three Notch Road, Hollywood, MD 31. Date filed (Month, Day, State 2008 Registrar

	by Funeral Director	Jaual Residence of Decedent Oa. State 10b. County Maryland Prince G Oe. Street and Number 4630 Pendall Driv 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	Te Table Table	ast birthday) Yrs. , Town or Lo	Fort If Under Months	Was 1 Year Days	hington If Under 24 Hrs Hours Min	8. Date of B	4c. Prth ay, Year)	Cor	
ral tor	by Funeral Director	Social Security Number 533-24-6911 Jsual Residence of Decedent Oa. State 10b. County Maryland Prince G Oe. Street and Number 4630 Pendall Driv 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	7. Age (In yrs. le 85 4. Age (In yrs. le 85 10c. City For 12. Was Decedent Ever in U.S. Agged Forces? 12. Yes 2 No	Yrs.	If Under Months cation	1 Year Days	If Under 24 Hrs	. (Month, D	rth ay, Year)	9. Birth Con	nplace (State or Fore untry)
tor	by Funeral Director	Jsual Residence of Decedent Oa. State 10b. County Maryland Prince G Oe. Street and Number 4630 Pendall Driv 1. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	eorge's For 10c. City	Yrs.	Months cation	Days		. (Month, D	ay, Year)	Cor	untry)
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d botolumo		15. Decedent's Edu	THE TA		Nas Dece f Yes, spe 1 □ Yes		spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or N rto Rican, etc.)	0-	14. Race - Amer Black, White Specify:	Africa
omula	npiete	15. Decedent a Edi	If Yes, Give Year or Dates: WW-II	16a, Deced	lent's Usu	al Occuna	ation		16b Ki	ind of Business/l	American
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a d	2	7. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle			
3 2	0	Charles Carring	ton				Inoli	a Willi	ams		
		19a. Informant's Name/Relationship (7	ype. Print)	19b. Mailir	ng Address	S (Street a	and Number or F	lural Route Num	ber, City o	or Town, State, Z	lip Code)
Ď	_	Regina Ebuwei - D						Washin Date		MD 207	
5	1	20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐	Hemoval from State	lace of Dispo emetery, crer	natory or o	other place	e) to Aug	15, 2008			
1	-	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Dicapa	<u></u>							al Home	tenham, MI
ouce.		The Sendar	DI MAN IT							gton, D	-
		23a. Part1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused the death	n. Do not ent	er the mod	de of dyin	g, such as cardia	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	dical Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a consequence) Due to (or as a consequence)								
A deicie	sician/me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome pf pregna 1 □ Live birth 2 □ Fetal 4 □ Pregnant at time of de 9 □ Unknown	Ideath 3	∃Ectopic p ∃ Other <i>(s</i> į					23d. Date of del Month	ivery Day Year
9	by Phys	Part II. Other significant conditions co	ontributing to death but not resu	ulting in the u	nderlying o	cause give	en in Part I.				the cause of death?
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	Completed							24a. Wa aut per 1∐ Yes	opsy formed?	prior to death?	utopsy findings availa completion of cause 2 No
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F		1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inpatient 2 2	ER/Outpatier 28b. Time o		υ Λ	4 🗆 Nursing	Home 5 Re 28d. Describe		6 ☐Other (Spe rv occurred	cify)
in a tipe	Certification:	1 Accident 5 Pending investigation 3 Suicide 6 Could not be	Injury ome, farm, str	М		ć? Yes 2 □ No		· ·		ural Route Number,	
4	Cer	4 Hornicide	building, etc. (Specify						own, State		
100	Medical	29a. Certifier (Check only one) 1 ☐ Certifying Phy 2 ☐ Medical Exam	ysician: To the best of my knowing: On the basis of examination and manner stated.	wledge, deat tion and/or in	h occurred vestigation	dat the tin n, in my o	ne, date and pla pinion, death oc	ce, and due to th curred at the tim	e cause(s e, date an	s) and manner as ad place, and due	s stated. e to the cause(s)
Modical Confication: To Bo	Me	29b. Signature and title of certifie	and marrier states		29	c. License	e number		29d. Da	ate signed (Mont	h, Day, Year)
		> Sonke la	rolly, MD.		M	D# D	0058627		AUGU	ST 11, 2	2008
	-	30. Name and address of person who		23a) (Type,	Print)						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Day Ye ar Carpenter, Sr. 5:34 PM Leonard Eugene August 2008 16 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Washington Washington County Hospital Hagerstown 8. Date of Birth (Month, Day, Year) Nov. 18,1946 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign Days Hours Months 1 X M 2 □ F 61 Maryland 219-44-4944 Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 217 No West Virginia Falling Waters Berkeley 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 93 Policemans Club Road 25419 U.S.A. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Tyes 2 □ No 1966— If Yes, Give Year or Dates: 1971 1 Never Married 2 X Married 1 ☐ Yes 2 No white Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) State of Maryland master plumber 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lawrence Roland Carpenter Rosie Anna King 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Post Office Box 85, Falling Waters, West Virginia Ruth V. Carpenter - wife 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Lawn Memorial
Park 20c. Location - City or Town, State August 20, 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lice 22. Name and Address of Facility Minnich Funeral Home tti 415 East Wilson Blvd., Hagerstown, Maryland 21740 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of lostridium Gayasinally not conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 4No 3 Probably 4 Unknown Commany 1 Yes 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 1 □Yes 2 ☑No 25. Was case referred to medical examiner?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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r than "natural", or items 23a or 28a-f show the Medical Examinar must be notified at

within 72 hours after

ges 1 and 2 should be filed vit of Health and Mental Hygis It item 27 is marked other?

permit. Page Department o Important: If any Injury or

Pages 1

Baltimore, Maryland 21215-0036

The law requires that the death certificate be executed and y physician ar attending p signed by the a has

Box 68760.

P.O.

certificate

Physician/Medical \$ Completed To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director; After this certifica completely filled in by the funeral director, p Be Certification: To Medical

Division of Vital Records, 3H-4H State

31. Date filed (Month, Day, Year) AUG 1 8 2008

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

1 ☐ Yes 2 ☐ No

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) D62588 August 164, 2008 anguagas

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

Hagerstown M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUDITH MBAOUA 251 E. Anticham St,

28a. Date of Injury (Month, Day, Year)

32. pgistrar's Signature

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

Registrar

State

29b. Signature and title of certifier

Susan K. Ross,

516 Washington Ave. Chestertown, MD 21620 31. Date filed (Month, Day, Year) 2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M.D.

and manner stated.

in D



Registrar

29c. License number

1)17036

29d. Date signed (Month, Day, Year)

8122/08

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene aaco hlth dept 08/15/08 dlw Reg. No. 2008 27555 1 - State Registrar Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 07 2008 11:15 AM August Carmen Elaine Christian-Fowler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel 362 Hall Road Crownsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 1/17/1947 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday **Funeral** Days Country) VA Hours 1 □ M 2**X2X** 217-52-2827 Director 61 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits sa or 28a-f show t be notified at 10a. State 10b. County MD Anne Arundel Crownsville 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with ms 23a 362 Hall Road 21032 USA 362 Hall Rd. Funeral 14. Race - American Indian 12. Was Decedent Ever in U.S Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) an "natural", or items Medical Examiner mu 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or ite 1 ☐ Yes 24☐ If Yes, Give Year or Dates: 1 Never Married XX Married 20XNo White Baltimore, Maryland 21215-0036 1 □ Yes XX No Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) the Photo Lab Receptionist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Henry Christian Elaine Pennington 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) epar ment of Health a mporant: If item 27 is ny injury or other tra Larry Fowler 362 Hall Rd. Crownsville, MD 21032 Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State Our Lady of the Fields 8/11/2008 Millersville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. rermit ny ir 12 Ridgely Ave. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** 26 month Lun /Medical Due to (or as a conce of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter ordering Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. physician Physician/Medical as attending IF FEMALE: use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Month for in the past 12 months? Year Day 4□Pregnant at time of death 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown þ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performe 1 ☐ Yes 2 ☐ No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA ٩ this To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director; After th completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After t Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) August (8, 2008 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) J. Hanover 1 3001 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 **AUG 1 5** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** 7:00 aM Lily V. David August 07 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 🗷 F 78 September 21,1929 India **Director** 219-11-7079 Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits Show If than "natural", or items 23a or 28a-f sho 1 ☐ Yes 2K No Director Maryland Prince George's Adelphi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death v 9511 Bucklodge Court 20783 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐Yes 2 No þ Specify 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry 16a. Decedent's Usual Occupation within 72 (Give kind of work done during most of working life. DO NOT use retired) is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othn any injury or other traumatic avant 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Solomon Thomas Albana Mentor ပ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bernice Samuel - Daughter 9511 Bucklodge Court, Adelphi, Maryland 20783 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) George Washington Cemetery 08/11/2008 Adelphi, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pneumonia /Medical Due to (or as a consequence of) Examiner Right Lung Collapse Sequentially list conditions, if any, leading to immediate cause. Enter thin entities (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) executed Exami Failure to Thrive and Due to (or as a consequence of): Box 68760. attending physician certificate be Physician/Medical the as nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy or Month in the past 12 months? Dav Year 5 Other (specify) □Yes 2□No Ö the 9 Unknown 9 Unknown signed by a <u>a</u>. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, by 2 No 1 🗌 Yes 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No certificate has autopsy 1 ☐Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) filled in by the funeral 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After Division Hospital or Attending 1 Natural 5 Pending investigation To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) ical 29a. Certifier Medi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

AUG 12 DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Kshama Garg, M.D., 1500 Forest Glen Road, Silver Spring, Maryland 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State o	of Marylan		rtment tificate		ealth and I Death		giene 2 Reg. No.	008	27557
H	Physicia		Decedent's Name (First, Middle,							2. Date of Dea		Year	3. Time of Death 5: 30
ŧ	/Medic			erie Doa						August		.00 ⁸ 8°	A M
	Examin	er	4a. Facility Name (If not institution,					own, or P1a	Location of Death	1		ity of Death lar1es	
	Funeral		Charles County No. Social Security Number	S. Sex	7. Age (In yrs. i	last birthday)	If Under	1 Year	If Under 24 Hrs.	8. Date of Birt	h	9. Birth	place (State or Foreign
	Director		213-22-0300	1□M 2ÅF	9:	1 Yrs.	Months	Days	Hours Min.	August 2	1916	Georg	gia
	DQ		Usual Residence of Decedent 10a. State 10b. County		100 Cib	y, Town or Loc	notic o						10d. Inside City Limits
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	the M	ecto	Maryland Char 1 10e. Street and Number	Les	W	aldorf	10f. Zip	Code			10g. Citizen o	f What Cou	
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	deeth with the Maryland ma 23a or 28a-f show rmust be nullflad at	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in U.	S. 13. V	Vas Deced		spanic Origin? (S n, Mexican, Puert	pecify Yes or No-		ace - Amer	
٥	or ite		1 Never Married 2 Marrie	Armed Ford 1 □ Yes If Yes, G	201No		Yes, spec		n, mexican, Puen Specity:	o rican, etc.)	Spec	lack, White	, etc.
1215-0036	hours after tural', or ite	d b	3 Midowed 4 □ Divorced	Year or E	Dates:							Wh	ite
ភ	"natu	lete	15. Decedent's (Specify only highest	Education grade completed))	16a. Deced	ent's Usua kind of wor	k done o	ation fu <i>ring most of wor</i>)	rking	16b. Kind of	Business/li	ndustry
7	within 72 ene. than "nai	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	1			rator		Teleph	one (Company
0	be filed within 72 hours after deeth with the Marylar at all typiene. All typiene. All typiene. All the Maclical Examinar must be notified at event, the Maclical Examinar must be notified at	Be Co	17. Father's Name (First, Middle, L.	ast)						ne (First, Middle,			
land	lid be fental rked o	To B	Wilbur Belk						Katie	Belle J	Jones		
Mary	2 should be and Mental Is marked o raumatic eve		19a. Informant's Name/Relationshi	p (Type, Print)		19b. Mailin	g Address	(Street a	and Number or Ru	ıral Route Numbe	r, City or Tow	m, State, Zi	p Code)
	and 2 satth a n 27 I		Mary Jeanette Way /	Daughter		A company of the second			e Lane, Wa		•		
Baltimore,	permit. Pages 1 and 2 should b Department of Heath and Menta Important: If Item 27 is marked any injury or other traumatic a <u>once</u> .		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3	B ☐Removal from	State	lace of Disposemetery, crem					20c. Locatio		
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g R	permit Deper Impor Impor Impor Impor		21. Signature of Funeral Service Li	censee	Di:								Home, P.A.
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			shock, or heart failure. List o Immediate Cause (Final	nly one cause on	each line.		\						Interval Between Onset and Death
*	Physician /Medical		disease or condition resulting in death)	a. Al	Cor as a consequence	mer	S	U	emer	4101			
	Examiner				(or as a somood	ubileo ory.							
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g	etten etten I for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	birth 2 ☐ Feta mant at time of d	Ideath 3□	Ectopic pr Other (sp					Month	Day Year
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VItal	Physician: Th rthis certificate ral director, pag	Be	25. Was case referred to medicat examiner?	Monitali				0#		ath (Check only o			
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5	ding I After funer	llon	1 Natural 5 Pending 2 Accident investiga		of Injury nth, Day Year)	Injury	м	8c. Injur Wor	yat k? Yes 2 ∐No	Zod. Describe	low injury occ	unea	
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	To the Hospitel or Attending Pl within 24 hours atter death. To the Funeral Director: After the completely filled in by the funeral		29a. Certifier 1 Certifying	Physician: To the	e best of my kno	wledge, death	occurr <i>e</i> d	at the tin	ne, date and place	e, and due to the	cause(s) and	manner as	stated.
	the H iin 24 the Fr	Medical	one)	xaminer: On the and made	nner stated.	mon and/or in				JII BU AT THE TIME,	17.7		15511
	with To T	2	29b. Signature and title of certifier	_	ma				e number	- 1	29d. Date sig	ped (Monti	, Day, Year)
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	200		30. Name and a cress of person w			, , , , ,	,	01 6	C +	Man 1	-1 007/4		
	Sta	te	Fatima Hussein, M. 31. Date filed (Month, Day, Year)		4			u- UI, (amp Spring	s, rarylar	<u>10 20/46</u>		
	Regist		AUG 2	2000	angistrar's Signa	K A	no the						

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 18 **Physician** P^{M} 2:28 2008 August Jane Clarke Downer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Great Mills St. Mary's 22204 Bay Arbor Way Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Days 1 □ M 2**XX**F Yrs. 66 01/10/1942 Massachusetts Director 016-30-8210 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be rediffed all 10a, State 1 ☐ Yes ŽXNo Director Great Mills Maryland | St. Mary's 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 72 hours after death with United States 22204 Bay Arbor Way 20634 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify Specify: White 3 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Hygiene. Elementary/Secondary (0-12) Financial Analyst U.S. Government Health and Mental Hygie em 27 is marked other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Richard Clarke Shaw Elizabeth Robbins ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1100 Anderson Street Fredericksburg, VA. 22401 Page Downer / Son other t permit. Pages 1 and Department of Heald Important: If item 2 any injury or other I Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brinsfield-Echols Cre. 08/20/2008 Charlotte Hall, MD. 22. Name and Address of Facility Brinsfield Funeral Home, P.A. 21. Signature of Funeral Service License Kyle S. Simons M01206 22955 Hollywood Road Leonardtown, Maryland 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Box 68760. attending physician Physician/Medical the as IF FEMALE nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day ρ in the past 12 months? 1 ☐ Yes 2 Z No 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by t I be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one, Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred e Hospital or Attending P 24 hours after death. e Funeral Director: After t After t Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide 24 hours a 🔀 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the h within 2. To the F 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of pers in wife completed cause of death (Item 23a) (Type, Print) 40900 Merchants Lane, Suite 205, Leonardtown, MD Jennifer Schmidt, D.O. 32. Registrar's Signature 31. Date filed (Month, Dy, Year) State Registrar AUG 2 2008

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State of Maryland / Department of Health and Mental Hygiene 2 0 0 0

		1	For State Registrar	Otate of Mar		rtificate of	Death	R	eg. No.	JUB	21009	
94	Dhoolais		Decedent's Name (First, Middle,	Last)				Date of Deat Month	th Day	Year	3. Time of Death	
A)	Physicia /Medic	al -	DAVID E. DABE					AUGUST	7	2008	4:30PM M	
	Examin	er	4a. Facility Name (If not institution,			4b. City, Town, c	r Location of Death		4c. Cour	ity of Death TALB ()Tr	
	Francis		11778 KITTY'S 5. Social Security Number		In yrs. last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth	Vaarl		ace (State or Foreign	
	Funeral Director		219-80-0745	1 XM 2 □ F 4	8 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day JULY 30	,1960	MARY	LAND	
	pu ,		Usual Residence of Decedent 10a. State 10b. County	1	0c. City, Town or Lo	ocation				10	d. Inside City Limits	
	shov shov	5		LBOT	CORD						1 XYes 2 No	
	the N 28a-f notifie	rect	MD TA 10e. Street and Number	LDUL	COKD	10f. Zip Code		1	0g. Citizen o	of What Count	ry?	
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	death	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.		Hispanic Origin? (Spo an, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. R	14. Race - American Indian, Black, White, etc.		
36	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show than must be notified at he Medical Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☐ Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? d 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 【No	Specify:		Spe	Specify: WHITE		
21215-0036	hour	ed b	15. Decedent's	Education	16a. Dece	dent's Usual Occu	pation		16b. Kind of	Business/Ind	lustry	
215	hin 72 e. an "na Medic	Completed	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4or 5+)	life.	DO NOT use retire	during most of work ed)			~ 0.11 G ## TO T	.amron	
	filed with Hygiene. other thar	Con	12	0	CAR	PENTER	18, Mother's Name			CONSTRU	JCTION	
Maryland	be file	Be	17. Father's Name (First, Middle, L					e (First, Middle, RET SIEG		ате)		
ryla	should be I nd Mental I marked o	ဥ	VERNON DABRASKY 19a, Informant's Name/Relationshi		19b. Maili	ng Address (Stree	t and Number or Rur			vn, State, Zip	Code)	
Ma	and 2 sho ealth and n 27 is me		BRENDA LESSNER/		l l		S CORNER I					
ē,	of Health item 27		20a. Method of Disposition		20b. Place of Dispo cemetery, cre	osition (Name of ematory or other pla	ace)	Date	20c. Locatio	n - City or To	wn, State	
im	Pages ment of h ant: If ite ury or of		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp	ecify)	CHESAPEA	KE CREMA	TION CTR	8/12/200	8 STE	VENSVII	LLE, MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at one.		21. Signature of Funeral Service L			2. Name and Addr	ess of Facility HELFENBETI	N & NEWN	AM FU	NERAL I	HOME PA	
	40 = 60		23a. Part1. Enter the disease, or o	MERCEV			RRISON ST			21001	Approximate	
	Dhuaisian	177	shock, or heart failure. List of Immediate Cause (Final	nly one cause on each line		_					Onset and Death	
	Physician / /Medical		disease or condition resulting in death)		consequence of):	19 0	renoma				211.0	
	Examiner		Sequentially list conditions	b								
	ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of):							
	tificate be executed ig physician and as the burial-transit	ledical Examiner	that initiated events resulting in death) Last	cDue to (or as a	consequence of):							
68760,	e be e sician burit	calE		d								
	tificat ng phy as the	ledi										
Вох	death cer e attendir d for use	an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pi 1 ☐ Live birth 2	Fetal death 3	□Ectopic pregnan	су		23d.	Date of delive	ery Day Year	
0.	n requires that the death cer been signed by the attendin should be detached for use	Physician/	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at ti 9□Unknown	me of death 5	Other (specify)						
Δ.	that the operation of t		Part II. Other significant conditio	ns contributing to death but	not resulting in the	underlying cause g	iven in Part I.	23e. Did to	obacco use o	contribute to t	ne cause of death?	
Records,	requires that sen signed b rould be deta	d by						1 🗆 🗅	∕es 2□N	o 3□ Prob	pably 4 Ninknown	
000	aw rec is bee 2 shou	Completed						24a. Was	an 24	4b. Were auto	psy findings available mpletion of cause of	
	sician: The law certificate has b irector, page 2 s	mo						perfo	rmed?	death? 1 □ Yes	2 □ No	
/ita	nysician: nis certifica I director, [Be (25. Was case referred to medical examiner?	Licenite!			26. Place of Dea					
or Vital	> . <u>∞</u> ₽	은	1 ☐ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatien	t 2 ER/Outpatie	aur 2 DOA		ome 5 XResid			(y)	
On	fter	tion:	1 → Actident 5 Pending Investig	(Month, Day	Year) Injury	W	ork? □Yes 2 □No		,,			
Division	Atten r deat ector: by the	fica	3 Suicide 6 Could n 4 Homicide determi	ot be 28e Place of injur	y - At home, farm, s	treet, factory, office	е	28f. Location (S City or Tox	Street and No	umber or Run	al Route Number,	
Ö	tal or / s after al Dire ed in b	Certification:										
	To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (29a. Certifier 1 Certifyin (Check only 2 Medical I	Physician: To the best of xaminer: On the basis of and manner stat	f my knowledge, dea examination and/or i	ath occurred at the investigation, in my	time, date and place y opinion, death occu	e, and due to the irred at the time,	cause(s) and date and pla	d manner as s ace, and due t	stated. to the cause(s)	
	o the	Med	29b. Signature and title of certifier	and maininer state	ou.		nse number			gned (Month,		
	TLS		•	11/		0	(0627	0	8	11110	8	
	1		30. Name and address of person			Control of the last of the las				•		
	1		DAVID C. HALVE	00 10	1- O:		ITE 302,	EASTON,	MD 21	601		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AUG 1 1	2008 Assert	s signature	medi						

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008

Year

08

Baltimore

MD.

14. Race - American Indian,

BLACK

Black, White, etc.

23d. Date of delivery

29d. Date signed (Month, Day, Year)

08/19/08

Day

3 Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

3. Time of Death

0410

Birthplace (State or Foreign Country)

10d. Inside City Limits

Approximate Interval Between Onset and Death

140

Year

1 ☐ Yes 2 X No

PAPER

CHAHAL

To the Hospital or Attendia within 24 hours after death. To the Funeral Director: A

1 - State Registral

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALTIMORE, ND 21201 32/Registrar's Signature **ORIGINAL**

1184883217

State Registrar 29b. Signature and title of certifier

DILJON

31. Date filed (Month, Day, Year)

5

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician 20, 11:25 AM 2008 DAWSON McLAURIN CLAYBROOK JR. Aug. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Harford White Hall 4549 Manor Hill Drive | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | 2/29/1920 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 10**X**M 2□F Yrs. 230-18-6014 88 Virginia Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City. Town or Location rthan "natural", or Itama 23a or 28a-f ahov The Madical Examiner must be notified at 1 ☐ Yes 2 No White Hall Director MD. Harford 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21161 United States 4549 Manor Hill Road Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 2 White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e fliad within ei Hygiena. I other than " Elementary/Secondary (0-12) College (1-4or 5+) Mechanic Railroad 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pegea 1 and 2 should be file Department of Heelth and Mentel Hy Important: If Itam 27 is markad oth any liqury or other traumatic avent ang. Be Christopher McLaurin Claybrook Dawson Sr. Janie ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Jarrettsville, MD 3756 Jarrettsville Pike Philip Dawson (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c Location - City or Town State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) B/22/2008 Miskimon Virginia Providence Cem. 22. Name and Address of Facility 21. Signature of Funeral Seffrice Licerisee E.G. Kurtz & Son Funeral Jarrettsville, Maryland Home, P.A. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician days /Medical as a consequence of) POLYNEUROPATHY PUE Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner SPONDYLITIS ettending physicien and for use es the burial-trensit Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) ed by the Division of Vital Records, P.O. 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 | Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☑ No 5 Presidence 6 Other (Specify) ۵ 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 00 25886 ath (Item 23a) (Type, Print) 30. Name and address of pe O'DEA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 7 2008 Registrar

100

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Acce. Month 735 PM **Physician** 07 AU AELIUS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner SFLIS BURY Norsial hore WICOMICO Hacheria If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 1 M 2 □ F 85 Yrs. NC 4105/1923 242-22-1448 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Item 27 is marked other than "neturel", or Items 23a or 28a-f show other treumstic event, the Medical Examiner must be notified at 1 Ves 2 No MD Wicomico Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3180 702 Taf 0+ 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No 11. Marital Status 2 should be filed within 72 hours after of and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 ff Yes, Give Year or Dates: 1944 Specify Specify: Black Completed by 3 ☑ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Automotive Elementary/Secondary (0-12) Mechanic 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Grace Edward Dixon Ann Dixa 2 James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) grand-Veronica Fleet-Taylor/daughter 1410 N. New Kirk St. Philadelphia, PA 19121 Item 27 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 13808 Hurlock MD Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Veteran's Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 917 W Isabella St. Salisbury, MD 21801 Bennie Snith Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finaf UNG CANCER **Physician** disease or condition resulting in death) /Medical Examiner MEMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (c. as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the at d be detached fo 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. TENSION 3 robably 4 □Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy has certificate 1 ☐ Yes 2 No Division of Vital director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death After 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. within 24 hours after death To the Funeral Director: , completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier **Medicai** 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier J₀ 2 1063433 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) #504B, MD21804 NEMAL DOSH 06 MUFORDST 32 Registrar's Signature Day, Year) 2008 Registrar

			For State Registrar		State	of Mar	yland / Der <i>Ce</i>	artmen ertificat	t of H e of L	ealth a D <i>eath</i>	and M		jienę) jeg. No.	008	27563
	Physicia	an	1. Decedent's Name (First								1,	2. Date of Dea Month	Day	Year	3. Time of Death
	/Medic	al	Goldie I 4a. Facility Name (If not in			umbarl		4h Cihr	Tours or	Location		manst	-	Ounty of Death	
	Examin	er	Fahrney-Kee				2			koro	OI DOZIII		40.0	Washir	
	Funeral Director		5. Social Security Number 215–18–1919		.Sex 1□M 2 ∑ F	7. Age	(In yrs. last birthda Yrs.	Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Jan . 7	Year) 1919	9. Birth Cou Ma	place (State or Foreign intry) ryland
pu	≥ :/:		Usual Residence of Deceding 10a. State 10b.	dent County		1.	10c. City, Town or	ocation							10d. Inside City Limits
Asivie	short and all	ō	Md.	•	hington			etown							1X Yes 2 □ No
the	r 28a-	rect	10e. Street and Number					10f. Zip					l 0g. Citize	en of What Cou	intry?
Đ Wị	23a o Mat be	alD	22429 God	ose S	it.			4	21720) 				U.S.A	
21215-0036	and Montal Hygiene. Is marked other than "natural", or itams 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 3 □ Widowed 4 □ D		12. Was De Armed f 1 Yes If Yes, G	Forces? 2 💆 No Sive		. Was Deced If Yes, spec 1 ☐ Yes	city Cuba	ispanic Or n, Mexica Specify.	n, Puerto F	cify Yes or No- Rican, etc.)		4. Race - Amer Black, White Specify: Wh	, etc.
5-0	"natu dical	letec	15. D (Specify only	ecedent's y highest	Education grade completed	i)	(Gi	edent's Usua e kind of wo	rk done d	durina mos	st of workin	ng	16b. Kínd	d of Business/li	ndustry
121:	than	Completed	Elementary/Secondary	(0-12)	College	(1-4or 5+) //re	DO NOT u	cash:					Colle	g e
Maryland 2	ntal Hygi od othar evant,	Be	17. Father's Name (First, I		*					18. Moth		(First, Middle,			
Iry le	Health and Mentam 27 Is marke	ဥ	19a. Informant's Name/Re				19b. Ma	ling Address	(Street	and Numb	er or Rura	l Route Numbe	r, City or	Town, State, Zi	ip Code)
2 7	5 to #		Ora F. Dela	uter	(Husban	d)	8507	Maple	vil.	l e Rd	. Boor	sboro,	Md. 2	21713	
Saltimore,	, ° = 5		20a. Method of Disposition 1X Burial 2 ☐ Crer 14 ☐ Donation 5 ☐ C	mation 3		n State	20b. Place of Dis cemetery ci Cedar La	oosition (Nar ematory or o WN Mei Park	ne of other place NOT1	21	Aug. 200	26, 28		ation - City or 1 gerstow.	
Balt	Departmen Departmen Important: any injury once.		21. Signature of Juneral S	Service Li	Pave			22. Name ar			-	12. Home sm	525 l ith s l	Bradbur burg,Md	y Ave. . 21783
	hysician and are provided by a set the private as the private transit transit to the private as	Ical Examiner													
Division of Vital Records, P.O. Box 68	y the attending phichad for use as the	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregrin the past 12 month 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			birth 2 gnant at ti	Fetal death	□Ectopic p					23	3d. Date of deli Month	very Day Year
rds, P	n signed by the a	by	Part II. Other significant of	condition	s contributing to	death but	not resulting in the	underlying o	ause giv	en in Part	I.				the cause of death?
of Vital Records,	ate has been sig page 2 should b	Completed												prior to death?	topsy findings available completion of cause of
/ita	certificate h	Be (25. Was case referred to examiner?	medical							e of Death	(Check only o	ne)		
on of \	h. After this c funeral dire	tlon: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 2 Accident	Pending	28a. Dat (Mo	Inpatient e of Injury onth, Day		_	28c. Injur Wor	4	2	ne 5 Residence R			tify)
Division at or Attending	within 24 hours after death. To the Funaral Director: A completely filled in by the ft	Certification;		Could no determin	t be 28e. Pla	ce of Injur Iding, etc.	y - At home, farm, (Specify)	street, factor	y, office		2	28f. Location (S City or Tox		Number or Ru	ral Route Number,
Hospital States	in 24 hour the Funara pletely fills	Medical (29a. Certifier 1 0 (Check only 2 N	Certifying Medical E	kaminer: On the	he best of basis of e inner state	my knowledge, de examination and/or ed.	ath occurred investigation	at the tir n, in my o	ne, date a pinion, de	nd place, a ath occurre	and due to the ead at the time,	cause(s) a date and p	and manner as place, and due	stated. to the cause(s)
	To 1	₹	29b. Signature and title of	f certifier	mulul			29		G O	391		29d. Date	signed (Month	n, Day, Year)
	2		30. Name and address of FARI	7	MUI	N-5	14 G 7		١	12 Ha	her	oral	h	ND 2	1740
	Sta Registr		31. Date filed (Month, Day		8	Registrar	's Signature	Les of			J		,	,	

Goldie, P, Delauter

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST 22,2008 Year **Physician** 9:04A M LEE DINTERMAN VIRGINIA /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 8. Date of Birth Month, Day, July 26, If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday Social Security Number 6 Sex ^{Year)}93<u>7</u> **Funeral** Months Days Min. Hours 1 □ M 2 🔻 F Maryland 71 214-36-1129 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the "horizal Examin or must be notified at 1 ☐ Yes 2 🛣 No Frederick Frederick Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21702 8016 Fieldstone Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Cleaning Service Owned & Operated 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event Be Agnes Heater John Wisner ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Husband 8016 Fieldstone Drive, Frederick, MD 21702 Mr. John W. Dinterman, Sr., 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Mount Olivet Cemetery Aug. 25, 2008 Frederick, MD 4 ☐ Donation 5 ☐ Other (Specify) ^{22. Name and Address of Facility} Keeney and Basford PA Funeral Home 21. Signature of Funeral Service Licensee MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one complications are completely shock to the complete shock to the complete shock to the complete shock to the complete shock to the comp Approximate Interval Between Onset and Death s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, se on each line Immediate Cause (Final disease or condition resulting in death) asotis **Physician** /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed and burial-tra Due to (or as a consequence of): Division of Vital Records, P.O. Box 687600 attending physician Physician/Medical as the IF FEMALE: nse 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23c. If ves. outcome of pregnancy 23d. Date of delivery ☐ Live birth 2 ☐ Fetal death 3 🗌 Ectopic pregnancy for Month Year 4 Pregnant at time of death 5 Other (specify) the detached 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ should be 1 Tyes 2 X No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform certificate 1 ☐ Yes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, I Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 □ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in a stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number D-13971 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert L. Kaufmann, M.D., 300 West Ninth Street, Frederick, MD 21701 31. Date filed (Month, Day, Year) AUG 2 7 2008 32. Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Harold Wayne EVERLY August 15, 2008 8:30 a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 13641 Village Mill Drive Maugansville Washington If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 218-34-3630 68 Director Oct. 25, 1939 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10b. County 10a. State 10c. City, Town or Location 10d, Inside City Limits d other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1XIYes 2 □No Maryland Washington Maugansville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 13641 Village Mill Drive 21767 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☒No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. ģ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) driver trucking 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any lipiry or other traumatic event once. 17. Father's Name (First, Middle, Last) Be Harold M. Everly Catherine L. Smith ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shirley A. Everly - wife 13641 Village Mill Dr., Maugansville, Md. 21767 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown Crematory | 8/16/08 Hagerstown, Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Maryland 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** LUNS month Conce /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease or anjury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physiclan: The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, signed by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 9 Unknown 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, <u></u> 1 ☑Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifler Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 41667 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nedical lomos 3H-5 32. Pagistrar's Signature 31. Date filed (Month, Day, Year) State Registrar **AUG 18**

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** Ouerubin 0. 8:36 P Fister August 9, 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Ft. Washington Hospital Ft. Washington If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday, **Funeral** Days Hours Months 1 XXX 2 F Aug. 28, 76 1931 Philippines | 572-98-5857 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.
Is marked other than "natural", or Items 23a or 28a-f show 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 📉 🛪 o Maryland Prince George's Ft. Washington Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11402 Gunpowder Drive 20744 USA Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Black, White, etc. 1 ☐ Yes 2 XXNo If Yes, Give Year or Dates: 1 Never Married 202 Married Baltimore, Maryland 21215-0036 Filipino 1 ☐ Yes 2XXNo þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Inspector - Board of Education Prince George's County 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Francisco Fister Concepcion Obregon မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pages 1 and 2 s ment of Health an Health ; Merlie Ordanes Fister / Wife 11402 Gunpowder Drive Ft. Washington, Maryland Department of Healt Important: If item 2 any injury or other once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition XX Burial 2 Cremation 3 ☐Removal from State Ft. Lincoln Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Aug. 16, 2008 | Brentwood, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Party Enter the disease, or complicato that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one course on each line. Approximate Interval Between Onset and Death Athorosyleration Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events.) Due to (or as a consequence of) Examiner The law requires that the death certificate be executed that initiated events and the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760 physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 9□Unknown signed by the at d be detached for 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 | Yes 2 | No 3 | Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2 No or Attending Physician: Was case referred to medical examiner? funeral director. Be 26. Place of Death Check onl one Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient Certification: To 1 Inpatient After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death. 2 Accident the 6 ☐ Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide Hospital 24 hours a 1 E Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1)005605 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arvind Narasimhan 11711 Livingston Road Ft. Washington, Maryland 31. Date filed (Month, Day, Year) AUG 1 3 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) **Physician** 10, August 2008 4:13 A. Leo Arthur Fletcher /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Hospital Center Prince George Cheverly
If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs **Funeral** Months Days Hours 79 Mitchellville, Md. 12/16/1928 Director 215-24-7854 Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County ral", or items 23a or 28a-f show Evandner is ust be notified at MXYes 2 □ No Director Md. P.G. Upper Marlboro 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number 2119 Sansbury Road Funeral 20774 U.S.A. 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 1 Never Married 25 Married Black "natural", or Yes Give 1 ☐ Yes 2 No Completed by 3 Widowed 4 Divorced Year or Dates: P.G. Co.Dept. of event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any Injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Public Works Truck Driver 5th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eugene Fletcher Nancy Wright P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Grace Fletcher/Wife 2119 Sansbury Rd., Upper Marlboro, Md. 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Resurrection Cem. 08/16/08 Clinton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility on & Sons Co., Inc. au 104 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or es o consequence of) Examiner OYONAS Se uentiall, list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examin attending physician and for use as the burial-tran Due to (or as a consequence of) Completed by Physician/Medical as IF FEMALE: ves, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3

Ectopic pregnancy Month Day Year 5 ☐ Other (specify) ☐Yes 2☐No the 9 Unknown 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an certificate 1 ☐Yes 2 ☑No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this filled in by the funeral 28a. Date of Injury 28b. Time of 27. Manner of Death 1 ☐ Natural 28c. Injury at Work? 28d. Describe how injury occurred 24 hours after death. Funeral Director: After (Month, Day, Year) 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier

To the I within 2

Hospital or Attending Physician; The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760.

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

Baltimore, Maryland 21215-0036

OTI 31. Date filed (Month, Day, Year) State 2008 Registrar

29b. Signature and title of certifier

MiD 32. Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

KOUL

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29d. Date signed (Month, Day, Year)

20748

Temple Hills, Md

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Day 2008 ear Fridie 11:30 A M Evelyn G. August 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Takoma Park Washington Adventist Hospital Montgomery If Under 1 Year | If Under 24 Hrs. 6. Sex Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Hours 1 □ M 2 1 F 578-42-7852 76 Director 1932 March 3. Washington, DC Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show 1 Yes 2 No Director District of Columbia Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 706 Geranium Street, NW 20012 United States by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: 1 Never Married 2 Married is marked other than "natural", or 1 □Yes 2√□No Specify Specify: 3 Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Librarian Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be ပ Maceo Mayo Ethel Mae Hunter 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Willmon Fridie, Jr. - Son 10107 Baltimore Ave. #4210 College Park, MD 20740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Quantico Nat'l Cemt. Aug 15, 2008 Triangle, VA 4 ☐ Donation 5 ☐ Other (Specify) ature of Funeral Service Lice 22. Name and Address of Facility Stewart Funeral Home, Inc. Benning Road, NE Washington, DC 20019 23a. Part Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine burial-transi Due to (or as a consequence of): physician Physician/Medical the attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 5 ☐ Other (specify) ed by the a detached f No 9 Unknown signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy page perform certificate l 2 🗆 No 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 XVo 2 ER/Outpatient 3 DOA 1 Unpatient Certification: To After this 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No neral Director: / 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

requires that the death certificate be executed Box 68760, P.O. Records, Division of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director: A

Baltimore, Maryland 21215-0036

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier



and manner stated.

AUG 1 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year)

08-06	6065		Please Type	or Print in Bla	ack Ind	elible Ir	ık. Ens	ure Al	I Copies	s Are Leg				
Thom	nas James I		ell, II State i- For State	e of Maryland /	Depart Certit	ment of ficate of	Health : Death	and M	ental Hy		. No.	200	8 2756	
	Physicia		Registrar 1. Decedent's Name (First, Middle,L	ast)						2. Date of Death			Time of Death	
Me	וי Exami		Thomas James Fa		August 8, 2	800		1209 hrs						
4			4a. Facility Name (if not institution, g			4	b. City, Towi	n, or Locat	ion of Death	4c. County of Death Prince George's				
			Bowie Health Center				Bowie	V 1 16 1	Indes 24Hm	8. Date of Birth		•		
	Funeral		, , , , , , , , , , , , , , , , , , , ,		e (In yrs. last	t birthday)	If Under 1 Months		lours Min.	1	6, 1954	Foreign	ry)New York	
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	ırylan Sa-f st	Director	10e. Street and Number	George 5	DOWL		10f. Zip Co	de		10	g. Citizen of W	nat Country	y?	
	he Ma or 28	흺	4227 Crosswick	Turn			20715	5			USA			
	with the 18 23a	<u>a</u>	11. Marital Status	12. Was Decedent		. 13. Wa	s Decedent	of Hispanio	c Origin? (Sp xican, Puerto	ecify Yes or No-		e - America e, etc.	n Indian, Black,	
	death r iten	Funeral	1 Never Married 2 X Marri	1X Yes 2	No					Modifi, Cto.)			Ì	
	after nI", o	by F		ed If Yes, Give Year † 72 or Dates:			Yes 2 X			ork dono	Specify: 16b. Kind of B	White		
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	4 with giene ther t	Com	17. Father's Name (First, Middle, La			THAIR	<u>, 141 11.</u>	18.M	lother's Name	(First, Middle, M	laiden Surnam	9)		
	215 oe file ital Hy ked o	Be (Thomas James Fa	rrell						scilla_				
	21 ould to d Men s mar lic eve	5	19a. Informant's Name/Relationship			ì				Rural Route Num			Zip Code)	
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23n or 28n-f show injury or other traumatic event, the Medical Examiner must be notified at once.		Kelly Lorraine F	arrell/ Wii	Ee Look B					Bowie, M	20c. Location	- City or T	own. State	
			20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Mary Land 20c. Location - City											
			4 Donation 5 Other Spe	tery 8/13/2008 Crownsville, MD Address of Facility Robert E. Evans Funeral Home										
			21. Signature of Funeral Service Li	censee						ert E. oad Bowi			al Home	
			23a. Part I. Enter the disease, or co	mplications that caused	the death.	Do not enter	the mode of	dying, such	h as cardiac o	or respiratory arr	est, shock, or h	eart	Approximate Interval	
	Physician M⊾dical		failure. List only one cause or	each line. a. Head and ne									Between Onset and Death	
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	Box 68760, e death certificate but the attending physic ed for use as the but	🚆	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outco	me of pregr		etal death	3	Ectopic pregn	ancy	23d. Date Month	-	ay Year	
	certi r certi endin use as	Ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown											
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	of Vital Records, P.O. Box 68760, ling Physician: The law requires that the death certificate be ex After this certificate has been signed by the attending physician funeral director, page 2 should be detached for use as the burial.	100	1 Yes 2 No			ER/Outpatie		Bc. Injury a	7 11013	ing Home 5	Residence 6		•	
	Ting F			28a. Date of In (Month, Day Aug 8, 2008	(Year)	1046 hrs	in injury 120		2 V No	Driver of	auto in a	rollover		
	Sion Attent death ctor:	catic	2 Accident Invest	gation 28e. Place of Injury - At home, farm, street, factory, office built								nber or Ru	er or Rural Route Number, City	
	Division of Vital Records, P.O. sepital or Attending Physician: The law requires that the hours after death. The remain Director: After this certificate has been signed by willed in by the funeral director, asked by edeach.	Certification:	3 Suicide 6 Could not be determined (Specify) Major Road / Highway S/B Race Track Road, Bow											
	spi hou file			veicion: To the hest of	my knowled	ne death occ	curred at the t	time, date	and place, ar	nd due to the cau	ise(s) and man	ner as state	ed.	
	To the Ho within 24 To the Fu	Medical	(Check only one) 2 Medical Exam	niner:On the basis of ex and manner state	camination a	nd/or investi	gation, in my	opinion, de	eath occurred	at the time, date	e and place, an	d due to th	e cause(s)	
4	5 in 5	Me	29b. Signature and title of certifier				29c.	License n	number		29d. Date s	gned (Mo	nth, Day, Year)	

State Registrar

State 31. Date filed (Month, Day, Year)

AUG 1 2 2008 32. Redistrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Margarita Korell MD.

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 9, 2008

			For State	State of Ma	ryland	-			nd Mental Hy	gien		0.0	275	70	
			Registrar		Certificate of Death							08	C / J	10	
	Physici /Medic	_	1. Decedent's Name (First, Middle, L	ast)	FEI	ر د د			2. Date of De	O Di		Year 0 8	3. Time of Dea	M	
	Examir	er	4a. Facility Name (If not institution, g				4b. City, Town, o		Death	4	c. County o		1 1		
			Mandrin Chesapea 5. Social Security Number 6.			est birthday)	Harwo		Hrs. 8. Date of Bit	8. Date of Birth			Anne Arundel 9. Birthplace (State or Foreign Country)		
	Funeral Director		036-18-8166 Usual Residence of Decedent	1 1 M 2 F	34	Yrs.	Months Days		Min. (Month, Da 11/12/	ay, Year	3	Coun O	hio		
	aryland show	,	10a. State 10b. County		10c. City,	Town or Lo						1	0d. Inside City L		
	the M	Director	Maryland Anne A	rundel		Anna	npolis			10g. C	itizen of W	hat Coun	try?		
	3a or	iO IE	2559 Golfers Ri	dge Rd.			214	01			USA				
	deat ems 2	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.S	13.	Was Decedent of H	Hispanic Origin	n? (Specify Yes or No Puerto Rican, etc.)	0-	14. Race	- Americ			
920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by	1 ☐ Never Married 2 ☐ Married 3 ∰ Widowed 4 ☐ Divorced		lo		1 ☐ Yes 2 ☐ No		dente i noun, etc.,		Specify:		hite		
Maryland 21215-0036	n 72 ho "natur edical	Completed	15. Decedent's (Specify only highest of	rade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retire	durina most o	of working	16b.	Kind of Bus	siness/Ind	dustry		
212	with jiene. r thar	E O	Elementary/Secondary (0-12)	College (1-4or 5- 2 years	+)	I	Homemaker				Hom	ie			
ğ	e filec al Hyg othe vent,		17. Father's Name (First, Middle, La			s Name (First, Middle		· ·							
ylai	Menta	To Be	Davis E.	Hill				A.	lberta Las	a Lassey					
Mar	2 sho and Ism		19a. Informant's Name/Relationship						or Rural Route Numb	-			Code)		
Baltimore, N	1 and Health em 27 ther t		Donald J. Felice 20a. Method of Disposition	/ Son	20b. Pla				, Arnold,		21012 Location - 0		wn. State		
	Pages nent of ant: If It ury or o		1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe				osition (Name of matory or other pla ans Cemet		/12/08		ownsv	-			
Balt	permit. Departi Importi any inj		21. Signature of Funeral Service Lie	ensec					George P.						
	Physician /Medical		23a. Part1. Enter the disease, or co shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	mplications that caused ly one cause on each lin a. Due to (or as a	Sto	Do not en					CWGCC		Approximate Interval Between Onset and Dea	ıth	
. Box 68760,	cate be executed was physician and the burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last	b											
	the death certifi y the attending I ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal	death 3[⊒Ectopic pregnand □ Other (specify)	Э			23d. Date Mor		ery Day Yea	ır	
s, P	ig.	by Ph	Part II. Other significant conditions	s contributing to death bu	ut not resul	Iting in the u	inderlying cause gi	ven in Part I.					ne cause of deat		
or Vital Rec	The law requires ate has been sign page 2 should be	Completed							24a. Was		24b. V	Vere auto	psy findings ava	ailable	
	Attending Physician: r death. ector: After this certific by the funeral director,	Certification: To Be C	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigat 2 Accident 3 Suicide 6 Could not determine	be 280 Place of init	ry <i>Year</i>)	ER/Outpatie 28b. Time o Injury me, farm, st	of 28c. Inju	her: 4 Nurs lry at lrk? Yes 2 No	of Death (Check only sing Home 5 Res 28d. Describe	one) sidence how in	6 Nother	MA er (Specif ed	VOR IN	FINE SE	
۵	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in it		(Check only 2 Medical Ex	Physician: To the best of aminer: On the basis of	f examinat										
	To the h within 24 To the F complete	Medical	29b. Signature and title of certifier	and manner sta				se number	3.8				Day, Year)	.fz	
J.	1		301 Name and address of person wi	to completed cause of de	eath (Item	23a) (Ţype	Pringt)	7 7	20	1.	rgu		1 000	8	
-	704		MICHAEL J	LalENTA	m	441	DEFEN	1st th	6HWAy F	1.00	APOL	JW	102140)		

State Registrar

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CERTIFICATE

2008 - 27571

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CERTIFICATE

2008-27237

				Please	Type or Prin						•		•		
			for State Registrar		State of Ma	aryiano		-	tment of F ficate of	lealth and f Death	vientai Hy	/giene Reg. No.	711118	27	572
	1. Decedent's Name (First, Middle, Last										Date of Death Months Day Ye			3. Time of I	Death
	/Medic	al	4a Eacility Name (letul	re street and number)	er			h City Town o	r Location of Death	8	7	Year County of Death	11.5	Spm
	Examin Funeral Director	er ∢	5. Social Security N Usual Residence of	Jumber 6.5	Nursy	te (In yrs. k		day)	F Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	Rd Lew 8. Date of Bi (Month, D	اند rth	9. Birth	pplace (State or intry)	Foreign
	yland how		10a. State	10b. County		10c. City	, Town	or Loca	tion					10d. Inside Cit	
	8a-fs	Director	MD.	PRINCE	GEORGES				LANHA	M				1 ☐ Yes	2 X No
	with the sa or 2	Dir	10e. Street and Nur		מגסמ שי				10f. Zip Code	06 2511			izen of What Cou	intry?	
36	hours after death with the Maryland tural", or items 23a or 28a-f show	by Funeral	8200 GOOD LUC 11. Marital Status 1 Never Married 2 Married 3 V Widowed 4 Divorced		12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:				s Decedent of I es, specify Cub	706-3511 Hispanic Origin? (Specify Yes or Niban, Mexican, Puerto Rican, etc.) Specify:			U.S.A. 14. Race - American II Black, White, etc. Specify: BLAC		
5-0036	72 hours "natural",	eted	(Spec	15. Decedent's E	ducation ade completed)		16a. [Deceder	nt's Usual Occup	pation	dina .	16b. Ki	ind of Business/Ir	ndustry	`
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d 2	e filed within al Hygiene. I other than "		17. Father's Name ((First, Middle, Last)			110	JHENAI.	18. Mother's Name (First, Middle, M				E	
/lan	permit. Pages 1 and 2 should be filed within 72 hc Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natuu any injury or other traumatic event, the Medical once.	To Be	C.RIE	OGLEY SO	COTT				ANNIE MUNDEI		L				
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altimore,			1 ∑X Burial 2 [•	Removal from State (y)	ST.	CA	CHE	RINE S	^{се)} СЕМ.8-2	26-08	l	CONCHIE		, 10
Balt			21. Signature of Fu	neral Service Lice	M0047	9	\mathcal{L}	722. N R L	AYMOND	FUNERAL FUNERAL A, MD. 20	SERV	ICE,	P.A.		
O. Box 68760,	bhysician be executed attending physician and attending physician and attending physician and the purial-transit a	dical Examiner	Immediate Cause (disease or condition resulting in death) Sequentially action if any, leading to imcause. Enter Under Cause (Disease or that initiated events resulting in death) Linding in de	(Final on mediate orlying injury	a. Due to (or as b Due to (or as c. Due to (or as	evi a consequ a consequ	ience of	r): r):	otko	Carollo	Vasa	hr	D Sen	Onset and D	leath
	at the death certificate I by the attending phys stached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent in the past 12 1 Yes 2	months?	1 Live birth	yes, outcome of pregnancy Live birth 2 Fetal death 3 Ectopic pregnancy Pregnant at time of death 5 Other (specify) Unknown							23d. Date of deli Month	•	'ear
rds,/P.	- 5 8 8	Completed by Ph	Part II. Other signif	ficant conditions	contributing to death b	ut not resu	liting in i	the unde	erlying cause giv	ven in Part I.			use contribute to		
of Vital Records,	The law requires ate has been sign age 2 should be	plete	Dysphapia Dementin 24a.Wa								s an 24b. Were autopsy findings available			available	
Ä		mo	Asomice 1 Tye							auto perl 1 □ Yes	topsy prior to completion of cause death? 1 □ Yes 2 □ No			ause of	
Vita	ysiclan: The iis certificate h director, page	Be (25. Was case reference examiner?		Hospital:				low	26. Place of Dea	th (Check only				
of	S : S : E	2	1 ☐ Yes 2 ☐		1 ☐ Inpatie	rv	ER/Outp		3 LI DOA		ome 5 Res		6 ☐ Other (Spec	cify)	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific, completely filled in by the funeral director,	Certification: To	27. Manner of Death 1. Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe how injury occurred								ral Route Numi	ber,			
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)		nysician: To the best miner: On the basis o and manner st	f examinat)
	To the within To the compl	Me	29b. Signature and	title of certifier	a Out	10	him	7	29c, Licens				ate signed (Month		
,			30. Name addr	1L A.	DEVO	RE	23a) (T	ype Pri	4203	71852 Jugar	stury	Na	1 HK1G	itsui	160
	Sta Registr		31. Date filed (Mont	th, Day, Year) AUG 2 7 2	32 Registr	ar's Signat	ture	dra	W			r		20'	121

Die

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 Month **Physician** 3:15 PM Barney L. Greenbaum August 6, /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Silver Spring 13123 Collingwood Terrace Montgomery 8. Date of Birth (Month, Day, Year)
Dec. 21, 1 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F 85 1922 Director Maryland 212-68-6722 Usual Residence of Decedent 10c. City, Town or Location 10d Inside City Limits 10a State 10b. County 28a-f show traumatic event, the Medical Examiner must be notified at Director 1 √ Yes 2 No MD Montgomery Silver Spring filed within 72 hours after death with the 10e. Street and Numbe 10f. Zip Code 10g Citizen of What Country? ō or items 23a 13123 Collingwood Terrace 20904 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 ₩ Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify. Specify: White þ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Medie once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) None Never Worked None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jack Greenbaum ည Sadie Harris 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Steven J. Kliegman - Nephew 9320 Many Flower Lane Jessup, MD 20794 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State King David Mem. Gardens 8/10/08 | Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Edward Sagel Funeral Direction, Inc. Donald .1091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Gastrointestinal Bleeding disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Uncertying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed and Due to (or as a consequence of): attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has page 2: autopsy Hospital or Attending Physician: The certificate 2 ☑ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 🔀 Residence 6 Other (Specify) 1∐Yes 2∏gNo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မှ this funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 X Natural death. 1 ☐Yes 2 ☐ No Director: 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by after 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signatur and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ျှ ٥ M) D36816 August 7, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10301 Georgia Avenue Marsha Seidelman, MD Silver Spring, MD 20902 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 12 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar 27574 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Рм Joseph L. Gaines 6, 2008 8:35 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6112 Westland Drive Hyattsville Prince Georges if Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days Hours 1**⊠** M 2□ F Yrs 172-28-6981 67 18, 1941 Johnstown, Jan. Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No Prince Georges **Hyattsville** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6112 Westland Drive 20782 U.S. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1 X Yes 2 No If Yes, Give 1964-66 Year or Dates. 1 ☐ Never Married 2 Married 1 ☐ Yes 2K No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Distrcit of Columbia 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harry Gaines Eleanor Williams 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Monica Gaines / Daughter 8116 Elora Lane Brandywine, MD 20613 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Gate of Heaven 8/13/2008 Silver Spring, MD 21. Signature of Fune al Service Licenses 22. Name and Address of Facility McGuire Funeral Service, Inc. ndre 7400 Georgia Ave., N.W. Washington, D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Malignant Neoplasm, Colon Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events. Due to (or as a consequence of) f delivery Day Year ite to the cause of death? ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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ral", or items 23a or Examiner must be r

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Mental

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nt of Health a t: If item 27 is y or other tra Pages 1 and

permit. Page Department o Important: If any Injury or once.

Director

Funeral

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Completed

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2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

burial-transit and the use : the signed by det has been page this certificate filled in by the funeral

Hospital or Attending Physician: The law requires that the death certificate be executed

hin 24 hours after death the Funeral Director:

Division or Vital Records, P.O. Box 68760-

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	/Medical
	Physician
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	ompleted

Examine Be Certification: To

resulting in death) Last		Due to (or as a conseq	guence of):							
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2	3c. If yes, outcome pf pregnation 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of c	al death 3□Ectop					23d. Date of do Month	elivery Day	Year
Part II. Other significant condit	ions con	tributing to death but not res	ulting in the underlyi	ng caus	e given in Part I.	-	23e. Did tobacco		to the cau	
						-	24a. Was an autopsy performed? 1□ Yes 2X No	prior to death?	completion	ndings available on of cause of
25. Was case referred to medica	al				26. Place of De	eath (Ch	neck only one)			
examiner? 1 ∐ Yes 2 ☒ No	Н	ospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3	DOA	Other: 4 Nursing	Home	5 X Residence	6 □Other (Sp	ecify)	
Z L Mooldon	igation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c.	Injury at Work? 1 ☐ Yes 2 ☐ No	28d.	Describe how inju	ry occurred		
3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ		28e. Place of injury - At he building, etc. (Specif	ome, farm, street, fac fy)	ctory, o	ffice	28f.	Location (Street ar City or Town, State	nd Number or F	Rural Rout	e Number,
29a. Certifier 1 ★ Certifyi (Check only one) 2 Medical	i Examir	ician: To the best of my knowner: On the basis of examina	owledge, death occur ation and/or investiga	rred at t	the time, date and place my opinion, death occ	ce, and	due to the cause(s) and manner a d place, and du	s stated. ie to the c	ause(s)

State Registrar

Medical

(Check only one)

29b. Signature and title of certifier

Dr. Dona Leskuski

31. Date filed (Month, Day, Year)

9200

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Basil Court #200 Largo, MD 20774

29c. License number

1-106665

29d. Date signed (Month, Day, Year)

August 8, 2008

			For State	State of	of Maryland		rtment of H		and Me	ntal Hyg	giene Reg. No. 2 (ากถ	27575
			Registrar			Cer	tificate of t	Jeam				100	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle							Date of Dea Month	Day	Year	
 	/Medic	al	Margaret	Marie	Golson					August	6, 20		5:30 A ^M
	Examin	er	4a. Facility Name (If not institution				4b. City, Town, or		of Death			ty of Death	
1 10		Q.	Saint Thomas I				Hyattsv If Under 1 Year	ille If Under	24 Hrs 0	. Date of Birtl	h		eorge's
п	Funeral		5. Social Security Number	6. Sex 1 ☐ M 2 ☐ ¥F	7. Age (In yrs. la	Yrs.	Months Days	Hours	Min.	eb 27,	Year)	Cour	ntry)
Ш	Director		579-62-2253 Usual Residence of Decedent		64				F	ED 21,	1944	North	n Carolina
	and and		10a. State 10b. County		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
	/laryl f shc ed a	ō	Manage 1 D 4 and	1		M-	11						1 ☑ Yes 2 ☐ No
	the N	Directo	Maryland Prince	e George'	s up	per ma	r1boro 10f. Zip Code				10g. Citizen o	f What Cour	ntry?
	with		5439 Thomas Sin	m Ioo Tor	raco		207	72			Unit	ed Sta	ates
	eath	Funeral	11. Marital Status		cedent Ever in U.S	i. 13. V	Vas Decedent of H f Yes, specify Cuba		igin? (Speci	fy Yes or No-		ace - Americ	can Indian,
	ter d	됩	1 ∑Never Married 2 Marri	Armed F	orces? 2 🔀 No				n, Puerto Ri	can, etc.)	В	lack, White,	
38	ırs al	by	3 ☐ Widowed 4 ☐ Divorced	I If Yes, G	ive		I∐Yes 2∏xNo	Specify:			Spec	cify:	Black
ŏ	2 hou	per	15. Deceden	it's Education		16a. Deced	lent's Usual Occup	ation	a of working	1	16b. Kind of	Business/In-	dustry
7.	nin 72 In "n Medi	ple	(Specify only highe Elementary/Secondary (0-12)	st grade completed,	(1-4or 5+)	life. L	kind of work done o	during mos ()	a or working				
212	s with	Completed	9 years		(1.10.07)		Clerk_				Pri	vate	
ğ	othe /ent,	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name (First, Middle,	Maiden Surn	ame)	
<u>a</u>	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or Items 23a or 28a-f show artic event, the Medical Examiner must be notified at	ToE	Roosevelt Gol	son						Mayo			
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at	ľ	19a. Informant's Name/Relations										code) 20772
Σ	and 2 valith is 27 i		Celia L. Golso	n - Siste		L	Thomas S						
Baltimore, Maryland 21215-0036	of He		20a. Method of Disposition 1☑ Burial 2 ☐ Cremation	2 Demousl from	20b. Pl	ace of Dispo emetery, crer	sition (Name of matory or other plac	:е)	Da	te	20c. Locatio	n - City or To	own, State
Ĕ	Page nent int: If		4 □ Donation 5 □ Other (5		Ft.	Linco	ln Cemet	ery A	ug 13	, 2008	Bren	twood	, MD
aĦ	mit. partn porta y inju		21. Si mature of Funeral Service	Licensee	11	22	2. Name and Addre	ss of Facili	ty Ste	wart F	uneral	Home	, Inc.
m	a m l		MONWOX	Mul	TI TIL		001 Benni					, DC	20019
	45.0		23a. Part 1. Enter the disease, or shock or heart failure. List	r complications that	caused the death	. Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between
	Physician	0.1	Immediate Cause (Final disease or condition		ebral In							- 1	Onset and Death
1	/Medical		resulting in death)	Due to	o (or as a consequ	ence of):							
	Examiner		On a subtieffice that a condition of	Art	erioscle	rotic	Heart Di	sease	:				
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Que to	(or as a consequ	enne offi							
	cutec nd ransi	Examiner	triat iritiated everits	с									
ó	e exe		resulting in death) Last	Due to	o (or as a consequ	ence of):							
68760,	death certificate be executed e attending physician and of for use as the burial-transit	dical		d									
		Med	IF FEMALE:	1	_								
Box	ith ce tendi	an/I	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live	utcome pf pregna birth 2 □ Fetal	death 3[Ectopic pregnancy	/				Date of deliv Month	very Day Year
0	e dez	Sici	1 ☐ Yes 2 ☐ No	4□Preg 9□Unk	gnant at time of de nown	eath 5	Other (specify) _						
Р.	that the death certificated by the attending produced for use as	Physician/Me	9 ☐ Unknown Part II. Other significant condition		dooth but not room	lting in the u	ndorlying course giv	on in Port		23a Did t	obacco usa c	ontribute to	the cause of death?
	requires that the leen signed by th hould be detache	by	Chronic Rena					en in i ait					bably 4 🖾 Unknown
ord	w requires been signed should be	Completed								,	103 2 11		babiy regonition.
ec	aw as b	ple	Hypertension	1						24a. Was auto	psy	prior to co	opsy findings available ompletion of cause of
<u> </u>	Th ate pag	5								1□ Yes	ormed? 2₺ No	death? 1 ☐ Yes	2□ No
/ita	Attending Physician: Thr death. ector; After this certificate by the funeral director, pag	Be (25. Was case referred to medica examiner?				100		e of Death	Check only o	one)		
7	hysion this on	2	1 ☐ Yes 2 💢 No		Inpatient 2			4 12614			dence 6 🗆		ify)
n	ding Ph J. After th funeral		27. Manner of Death 1 X Natural 5 □ Pendi		e of Injury onth, Day Year)	28b. Time of Injury	Wor			3d. Describe	how injury oc	curred	
Sio	tendi eath. or: A	cati	2 Accident invest 3 Suicide 6 Could	igation				Yes 2					and Day As All and Day
Division or Vital Records,	or Attendater death	Certification:	4 ☐ Homicide deterr	minod 200, Flat	ce of injury - At ho Iding, etc. <i>(Specif</i>)	me, tarm, st /)	reet, factory, office		28	City or To	Street and Ni. wn, State)	imber or Hui	ral Route Number,
	pltal or Attenions after deathers after deatheral Director; filled in by the		¥ a		L = L = -1 - f === l===		h 4 4b - 45		and place of	and advise des dibes	(-)	l mannar an	atatod
	Hos Funda ely	edical		ing Physician: To to it Examiner: On the	basis of examina								
	To the Hos within 24 hd To the Fun completely	Med	29b. Signature and title of certific		anner stated.		29c. Licens	se number			29d. Date sig	gned (Month	, Day, Year)
	₹ ¥ ₹ 8			2008.	200			26024	,		August		
•	F.		felil	1/10/	1100 of d==# /#	00a\ /T:		2.0024	+		August	. 109 .	2000
	0 (5)	1	30. Name and address of person Lester M. Mil				St., NE #	306 V	Vashin	gton.	DC 200)17	
1	- 64	ate	31. Date filed (Month, Day, Year				, "			J ,			
	Regist		AUG 1 2 2008	Bleen	Registrar's Signa								

			1- For amend #18 Per State Registrar	d / Depa 02/08 <i>i</i>	rtment of H	lealth ar Death	nd Mental H	ygiene Reg. No.	2008	27576
	Dhoutet		Decedent's Name (First, Middle, Last)				2. Date of	Death		3. Time of Death
	Physicia Medic/		WILLIAM VERNON GRIFFITH				AUGUS			9:10AM M
Ì.	Examin	er	4a. Facility Name (If not institution, give street and number) CAROLINE HOME FOR HOSPICE		4b. City, Town, or DENT (Death	4c.	CAROLI	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Min. (Month,	Birth Day, Yea <u>r</u>)	9. Birt	hplace (State or Foreign
ш	Director		213-24-0843 TALIM ZLIF 76 Usual Residence of Decedent	Yrs.			OCT	20, Year) 20, 19	31 MA	RYLAND
	yland Iow at			ty, Town or Lo	cation					10d. Inside City Limits
	e Mar a-f sh tified	ctor	MD TALBOT	EAST	ON					1 □Yes 2X No
	vith the	Director	10e. Street and Number		10f. Zip Code			10g. Citi	izen of What Co	1.2
	eath v Is 23a must	Funeral	6266 LANDING NECK ROAD 11. Marital Status 12. Was Decedent Ever in U	S 13 V		1601	n? (Specify Yes or	No-	14. Race - Ame	SA erican Indian,
0	officer of the office	Fun	Armed Forces? 1 ☐ Never Married 2 ▼ Married 1 ▼ Yes 2 ☐ No				n? (Specify Yes or Puerto Rican, etc.)		Black, Whit	
ğ	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show ent, the Medical Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:		I□Yes X □No	Specify:				HITE
<u>5</u>	n 72 h " natu	Completed	15. Decedent's Education (Specify only highest grade completed)	(Give	lent's Usual Occup kind of work done o OO NOT use retired	durina most c	of working	16b. Ki	ind of Business/	Industry
212	y withi	mo	Elementary/Secondary (0-12) College (1-4or 5+) 1.1 1	NA	VAL OFFIC	ER		U.S	. GOVER	NMENT
g	be filed within 72 hours after death with the Marylar tal Hygiene. do other than "natural", or items 23a or 28a-f show other, the Medical Examiner must be notified at	BeC	17. Father's Name (First, Middle, Last)			18. Mother's	s Name (First, Mido	lle, Maiden	Surname)	
Maryland 21215-0036	should be filed vind Mental Hygies marked other tumatic event, th	2	WILLIAM J. GRIFFITH	40h Marilin	an Address (Chana		OLARA DAW or Rural Route Nui			Zin Codo)
<u>a</u>	12 ha 7 is		19a. Informant's Name/Relationship (Type. Print) PATRICIA GRIFFITH/WIFE		,		ROAD, EA			• •
ē,	He He othe		20a. Method of Disposition 20b.	Place of Dispo	sition (Name of natory or other place		Date		ocation - City or	
altimore,	Pages nent of l ant: If its ury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State			i i	CR 8/6/20	08 S	TEVENSV	ILLE, MD
Balt	permit. Pages Department of Important: If i any injury or once.		21. Signature of Funeral Service Licensee	(~/) F	. Name and Addre	ss of Facility	BEIN & NE	WNAM	FUNERAL	HOME PA
	300	13.50	23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.						MD ZIOU	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Canc	er					Onset and Death 5 NACA
	/Medical Examiner		resulting in death) Due to (or as a consecutive conse	quence of):						3
		er	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consecutive and the conditions)	quence of):						
	cuted id ansit	Examiner	if any, leading to immediate cause. Enter Underhin. Cause (Disease or injury that initiated events c.							
90	ate be executed only sician and the burial-transit		resulting in death) Last Due to (or as a consec	quence of):						
09/89	ate the	dical	d							
Box (The law requires that the death certificate has been signed by the attending playage 2 should be detached for use as I	Physician/Me	IF FEMALE: 23c. If yes, outcome pf pregrant 23c. If yes, outcome pf pf pregrant 23c. If yes, outcom		7-				23d. Date of de	elivery
	death le atte	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ In the past 12 months? 4 ☐ Pregnant at time of a light paragraph.		Ectopic pregnancy Other (specify)	<i>y</i>		-	Month	Day Year
<u>Р</u> О	ires that the de signed by the a be detached f	Phys	9 Unknown	ulting in the Lu	adorhina onuno air	on in Dort I	220 D	id tobacco	uso contributo t	o the cause of death?
Vital Records,	signe d be d	by	Part II. Other significant conditions contributing to death but not re-	sularing in the di	idenying cause giv	en arraiti.				robably 4 Unknown
CO	w require been sig should b	Completed					24a. W	as an	24b. Were a	utopsy findings available
æ	The lav	dmo					— aı po 1□ Ye	utopsy erformed? s 2 XNo	prior to death?	completion of cause of
<u>ta</u>		BeC	25. Was case referred to medical examiner?			26. Place	of Death (Check on		7 1010	
	Physic this or	္	1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ 27. Manner of Death 28a. Date of Injury	ER/Outpatien		4 L. Nui:	sing Home 5 ☐ R			ecify) HOSPICE
Division or	ding h. : After funer	tion	1. Available of Death	Injury	Wor	yaı 1k? Yes 2.∐N		be now inju	ry occurred	
N S	ii or Attending P after death. I Director: After i d in by the funera	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of injury - At huilding, etc. (Spec] nome, farm, str	eet, factory, office		28f. Locatio	n (Street ar Town, State	nd Number or F	Rural Route Number,
	spital or Al ours after d teral Direc filled in by	Cert	Dallaing, vic. (open				Only or	rown, oran		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director,	edical	29a. Certifier 1 ★Certifying Physician: To the best of my kn (Check only one) 2 ★ Medical Examiner: On the basis of examination and manner stated.							
	To the Hos within 24 hd To the Fun completely	Me	29b. Signature and title of certifier		29c. Licens		. f	29d. Qa	ate signed (Mon	th, Day, Year)
	TLS		1, KASTEMDE, WO		C	7428	16	8	5/03	
	5+VA		30. Name and address of person who completed cause of death (Ite	/	/ -	ASTON	1 MP	216	.01	
	Sta	ite_	31. Date filed (Month, Day, Year) 32. Registrar's Sign	ature	, /		1		J	
	Registi		AUG 0 6 2008	N A	med	_				

ame per 08/	nd ling phy a 20/08	nes aac dl	s 1 & 23e Please T co hith dept c ^W For	ype or Prir State of Ma	nt in Bl aryland	ack In	delible Ink artment of I	. Ensure Health an	e All Copies d Mental Hy	Are Logiene	egible.	27577
			State Registrar 1. Decedent's Name (First, Middle, Last)			Ce	<i>rtificate of</i> es Gins	Death	2. Date of De	Reg. No.	_ 0 0 0	3. Time of Death
	Physici /Medio	cal	4a. Facility Name (If not institution, give s	J. C	710	_	4b. City, Town,		Month.	Day / O	Year O 8	2005 M
	Examir	ner	MANDRIN CHESAPEAKE			2		IARWOOD			NNE AR	
	Funeral Director		5. Social Security Number 6. Sex 219–32–6386	M 2□F 7. Ag	ge (In yrs. la: 72	st birthday, Yrs.	Months Days		Hrs. 8. Date of Bir (Month, Da FERUARY	th ay, Yea <i>r)</i> 22,193	9. Birth	nplace (State or Foreign untry) NSYLVANIA
442	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or L	ocation					10d. Inside City Limits
	a-f sho	ctor	MARYLAND ANNE ARU	NDEL			ANNAPO	LIS				1 ☐ Yes 2 No
	with the	Director	10e. Street and Number	TINTER# OF	202		10f. Zip Code	21401		J	n of What Co	
	ms 23	Funeral	631 ADMIRAL DRIVE,	12. Was Decedent Armed Forces?	Ever in U.S.	. 13.			? (Specify Yes or No Puerto Rican, etc.)		. Race - Ame	rican Indian,
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	by Fur	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ▼ Yes 2 □ If Yes, Give Year or Dates:	No 1 195	5	1 ☐ Yes 2 No		ruerto Hican, etc.)		Black, White	
15-0036	"natura	Completed	15. Decedent's Edu (Specify only highest grade	cation		16a. Dece	edent's Usual Occu e kind of work done DO NOT use retir	durina most of	f working	16b. Kind	of Business/	Industry
2121	withir jiene. r than the Me	dmo	Elementary/Secondary (0-12)	College (1-4or	5+)	mo.	BOILERMA			LOCA	L UNIO	N #193
nd	al Hyg	Be C	17. Father's Name (First, Middle, Last)						Name (First, Middle		urname)	
ylaı	iould by Ment	일	ALFRED GINS	D (0		405 84-11			ENCE THOM		Farris Chaha S	Zin Cadal
Maryland	id 2 sh Ith and 17 is n traun		19a. Informant's Name/Relationship (Ty.) ROBERTA M. GINS/WI	•			,		or Rural Route Numl INTT#9302 .			MD 21401
	of Heal		20a. Method of Disposition		20b. Pla	ace of Disp	osition (Name of		Date		ation - City or	
i E	Page ment c ant: If ury or		1 ☐ Burial 2 X Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)	lemoval from State	CHES	TER .	KE"CREMA	1	JGUST 15 2008	STEVE	NSVILL	E, MARYLAND
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		21. Signature of Funeral Service Licens	/ /	M00672	c C	22. Name and Add REMATION	ress of Facility I AND FUN POLTS	FELLOWS, I NERAL CARI MARYLAND	IELFEN PA 21201	BEIN A	ND NEWNAM BESTGATE
		Г	23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications hat cause	d the death.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	A	sbu	Acos	us					Onset and Death 6 Y Lerr
9	/Medical Examiner	ı	resulting in death)	Due to (or as	a conseque	ence of):						
		ē	Sequentially list conditions, if any, leading to immediate cause. Enter Underly in Cause (Disease or injury	Due to (or as	s a conseque	ence of):						
	executed n and ial-transit	Examiner	that initiated events	o								-
.09	be icia		resulting in death) Last	Due to (or as	s a conseque	ence of):						
68760,	certificate Iding physise as the	edic		J								-
Вох	th cert lending r use a	an/M	23b. was decedent pregnant	3c. If yes, outcome			□Ectopic pregnar	icy		23	3d. Date of de	
P.O. B	that the death ed by the atter detached for u	Physician/Medical	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant a 9□Unknown			Other (specify)				Month	Day Year
	requires that the de een signed by the schould be detached	by	Part II. Other significant conditions co	ntributing to death I	but not resul	lting in the	underlying cause (jiven in Part I.			e contribute to	o the cause of death?
o o	s een	olete							24a. Wa		24b. Were a	utopsy findings available completion of cause of
E Re	sician: The law certificate has irector, p.ge 2 s	Completed							— aut per 1∐ Yes	opsy formed? 2t2wo	death? 1 ☐ Yes	
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 No	Hospital:		-D/O 4	017.004	thor:	f Death (Check only		MAN	DRIN HOSPILE
0	Phy this	n: To	27. Manner of Death	1 ☐ Inpati 28a. Date of Inj (Month, D		28b. Time Injury	of 28c. In	4 LI Nurs	ing Home 5 ☐ Re 28d. Describe			House.
sior	endIn sath. or: Aft	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				M 1	☐Yes 2☐No				
Division or Vital Records,	after de Direct	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of in building, e	njury - At hor etc. <i>(Specify</i>	me, farm, s	street, factory, offic	е	28f. Location City or T	(Street and own, State)	Number or F	tural Route Number,
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, pege	edical C			of examinat				place, and due to the occurred at the time			
	To th within To th	Me	29b. Signature and title of certifier	Ren	Auu	n		nse number	t 38			th, Day, Year) 11,2008
	15×1		30. Name and address of person who	or pleted cause of	death (Item	23a) (Type	e, Print) DEFEN	SE HO	HWAY A	NNA	Pous 1	MD4401
	St Regist	ate trar	31. Date filed (Month, Day, Year) AUG 1 2 20	08 32 egis	trar's Signat	ture	book			-		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Dav Year Month 3:10 P M 2,2008 Griffith Herbert Meriwether III 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death County of Death Salisburg Wicomico RehabaNursina If Under 1 Year | If Under 24 Hrs. | V8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Numb 7. Age (In yrs. last birthday, Days Hours 221-36-5502 59 Washington, DC 3/20/1949 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 TYes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 507 E. College Ave. 21804 USA 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White, etc. 1 ☐ Yes 2€ If Yes, Give Year or Dates: 1 Never Married 2 Married 2€ No ive 1 ☐ Yes 2 ☐ No Specify. Specify: 3 Widowed 4 Divorced white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) route salesman Schmidt Baking Co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Herbert Meriwether Griffith Jr. Katherine Azalea Bowen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
7116 Collingsworth Place, Frederick,, MD 21703 19a. Informant's Name/Relationship (Type. Print) Erin M. Pare/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Other (Specify) Salisbury Crematory 7/8/08 Salisbury, MD 4 □ Donation 2. Name and Address of Facility Holloway Funeral Home Professional Association ture of Funeral Service Licenses 501 Snow Hill Rd., Salisbury, MD 21804 domosol Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to ear Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 → NO 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ∐ Yes 21 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient 27. Manner of Death 28a. Date of Injury 28b Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day Year) 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, or Attending Physician: **Physician**

/Medical

Examiner

Director

Funeral

Completed by

Be

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Examiner

Physician/Medical

Completed by

Be

Certification: To

Funeral

Director

7 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examiner once.

Physician

/Medical

Examiner

and the burial-tra

attending physician

the

þ signed to

page 2

certificate

this

Herber

3altimore,

filled in by the funeral After after death death To the Hospital o within 24 hours aft To the Funeral Di

Medical

29a. Certifier 1 🚾 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) William H. Robins isbur Di

State Registrar

	For State		State	i iviai yiai	•	rtificate of l		Mental Hygi	g. No.	008	27579
	Registrar 1. Decedent's Name (First	st, Middle, La	st)			Timodio or E		2. Date of Death			3. Time of Death
n I	wavne	Euge	ene G	Getzanda	anner			August	Day 19	2008	10:40A M
į	4- FWashings (16 4)	nstitution, giv	e street and nu	mber)		4b. City, Town, or	Location of Deat		4c. Cour	nty of Death	<u> </u>
	Northampto						derick			Frede	
	5. Social Security Numbe 220-54-4159		Sex IMDM 2□F	7. Age <i>(In yr</i> s. 59	last birthday, Yrs.	If Under 1 Year Months Days	Hours Min.		Year) 1 94 9	9. Birthp	place (State or Foreig otry) 'yland
	Usual Residence of Dece			7,7				11011 0,	י דירי	nat	yrand
		County		10c. Cit	ty, Town or L	ocation				1	0d. Inside City Limits
;	Maryland	Frede	rick			Frede	erick		0	/////	1 □Yes 2 🛛 No
		iborty	, Dd			10f. Zip Code	21701	10	g. Citizen d	of What Cour	-
	9513 L 11. Marital Status	Therty		edent Ever in U.	.S. 13.	Was Decedent of H	21701 ispanic Origin? (5	Specify Yes or No-	14, R	U.S.A	
		! ☐ Married	Armed Fo	2 📉 No		Was Decedent of Hi If Yes, specify Cuba		to Rican, etc.)		Black, White,	etc.
	3 □ Widowed 4 🛣 [Divorced	If Yes, Gi Year or D			1 □Yes 2 X No	Specify:		Spec		hite
)	15. [(Specify on	Decedent's Ed ly highest gra	ducation ade completed)		1 (Give	dent's Usual Occupa kind of work done of DO NOT use retired	furina most of wo		6b. Kind of	Business/In	dustry
	Elementary/Secondary	(0-12)	College (1-4or 5+)		& sewer	′	staller	C	onstru	action
ב מ		Middle, Last,	")		1		<u>'</u>	me (First, Middle, M			ice ron
2	11	lliam	Getzand	lanner S	Sr.		Carol	ine Eliza	beth (Grove	
	19a. Informant's Name/F	lelationship ((Type. Print)		19b. Mail	ng Address (Street a	and Number or R	ural Route Number,	City or Tov	vn, State, Zip	Code)
	Kathy L. St		daughte			ple Ave.		tlestown,			
	20a. Method of Disposition 1	mation 3				osition (Name of matory or other plac				on - City or To	
	4 ☐ Donation 5 ☐ 0			St.		Luth. Ce		2/2008 rtzler Fu		estown	, PA
	athan	3. O	(Mr)	Elen	1			Liberty			762
-	23a. Part1. Enter the dis	ease, or com	plications that	aused the deat						MD ZI	Approximate Interval Between
	shock, or heart failu Immediate Cause (Final	ire. List only	one cause on e	You Sa	nell	all Car	-111	,			Onset and Death
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disease or condition resulting in death) a. Due to (or as a					uence of):	an he	nev				MUNTHS
	resulting in death)	. (Due to	(or as a conseq Heta	nuence of):	ic hig	cant	er			MONTHS
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)
PRAYEET BELANUM, NO 196 TJ DAVE, FREDERICK, ND - 21702 31. Date filed (Month, Day, Year) AUG 2 7 State Registrar

29b. Signature and title of certifier

Registrar's Signature

29c. License number

00062223

29d. Date signed (Month, Day, Year)

Medical (

			For State Registrar	State of Maryla		epartme Certifica			nd Mental H	ygiene Reg. No.	Z U U C	3 27	580
			Decedent's Name (First, Middle, Last)					2. Date of	Death		3. Time o	f Death
	Physicia /Medic	_	Donna Sue	Hines					Aug.	08		5:40	РМ
	Examin		4a. Facility Name (If not institution, give			4b. Cit		Location of I			County of Dea	_	
		494	Prince George's I		a la at hinti	hadoud If I Inc	Hyati ler 1 Year	tsville				eorge s	or Fomian
	uneral irector		215-46-4353	THE OFFICE		rs. Month				Day, Year)	C	Lorida	or roreign
land	it ow		Usual Residence of Decedent 10a. State 10b. County	10c. (City, Town	or Location						10d. Inside C	City Limits
death with the Maryland	fied a	호	Maryland Prince G	eorge's	Co	ollege	Park					1 X Yes	2 □ No
h the	or 28a e noti	irec	10e. Street and Number	20192 3			Zip Code			10g. Citi	zen of What C	Country?	
th wit	23a c ust be	Funeral Director	9014 Rhode Island	Avenue			2074	40			USA		
	tems ler m	nue	11. Marital Status	12. Was Decedent Ever in Armed Forces?	U.S.	13. Was De	cedent of H pecify Cuba	lispanic Origir an, Mexican, I	n? (Specify Yes or Puerto Rican, etc.)	No-	 Race - Am Black, Wh 		
5-0036 72 hours after	n recuir any wenter rygener are them 23a or 28a-f show tien 21 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes	2 🔀 No	Specify:			Specify:	White	
ひ ら222	natur	Completed	15. Decedent's Ed (Specify only highest grad		16a.	Decedent's U (Give kind of	work done	durina most c	f working	16b. Ki	ind of Busines	s/Industry	
filed within 7	than "	Ig III	Elementary/Secondary (0-12)	College (1-4or 5+)		life. DO NOT	ose retired nemake	•		0	wn Home	e	
filed A	ther i	ပ္ပို	17. Father's Name (First, Middle, Last)			1101	- Indice		s Name (First, Mide				
<u> </u>	ked o	To Be	Henry Hoile					Ed:	ith Simmo	nds			
Maryla d 2 should th and Men	is mar aumat		19a. Informant's Name/Relationship (7	ype. Print)		•	•		or Rural Route Nu			• •	_
2 P #	n 27 i		Robert E. Hines /						zenue, Co				740
Baitimore,	_ = 5		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		Disposition (f y, crematory o			Date		ocation - City o		
	tant:		4 □ Donation 5 □ Other (Specify) Fo	rt L				3/13/2008				_
Germi	Important: any injury once.		21. Signature of Fundal Service Licen	see				ss of Facility	Home, P.A			imore A	
	è		23a. Part1. Enter the disease, or comp	lications that caused the de	eath. Do n						-	Approxima	ate
Phy	/sician	0 0	shock, or heart failure. List only immediate Cause (Final	one cause on each line.	4	1	1		· 60	1		Interval Be Onset and	l Death
	ledical		disease or condition resulting in death)	a. Due to (n) as a cons	equince o	of):	nu	- Jan	nja	un		1	
Exa	aminer		Sequentially list conditions	b	-								
pe	sit	Examiner	Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury	Due to lor to cons	equence o	of):							
xecut	and al-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a cons	equences	3f):	ner			7 1			
ox 68 / 60, certificate be executed	hysician and the burial-transit	ical		. Inke	ele	1/K	ne	e P	rolla	us	~		
58 tificat	ig phy as the	73											
BOX Bath cert	attending ph I for use as th	an/N	23b. was decedent pregnant	23c. If yes, outcome pf pred 1 ☐ Live birth 2 ☐ F		3 □Ectopi	c pregnanc	V 7 152	mmya	ted	23d. Date of d	lelivery Day	Year
. ö	the at hed fo	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time o 9□Unknown	of death	5 Other	(specify) _	Heri	26 (05)	ter	WORT	Day	Tea
That #	ed by detacl		Part II. Other significant conditions of	ontributing to death but not r	esulting in	the underlyin	g cause giv	ven in Part I.	23e. D	id tobacco	use contribute	to the cause of	f death?
VITAI RECORDS, P.O sician: The law requires that the	been signed by the should be detached	d by							1	☐ Yes 2	!□ No 3□	Probably 4	Unknown
	s beer	Completed							24a. V		24b. Were	autopsy finding	s available
2 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	age 2	E O								utopsy erformed? es 2 X No	death		cause of
	certificate ha irector, page 2	Be C	25. Was case referred to medical	\				26. Place	of Death (Check or	/	3		
Or V Physic	this certific al director,	ToE	examiner? 1 ☐ Yes 2 No	Hospital: Inpatient 2	□ ER/Ou	tpatient 3□	DOA Oth	ner: 4 🗆 Nurs	sing Home 5□F	esidence	6 □Other (S	pecify)	
Z E	Affer		27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year		Time of njury M	28c. Inju Wo 1 🗆	ryat rk?]Yes 2 ∐ N		be how inju	iry occurred		
DIVISION I or Attending	within 24 nours after deam. To the Funeral Director: , completely filled in by the f	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - A building, etc. (Spe	t home, fa	rm, street, fac	tory, office			n (Street a Town, Stat		Rural Route No	ımber,
pital	erai C		29a. Certifier 1 Certifying Ph	ysician: To the best of my l	knowledge	death occur	red at the t	ime, date and	place, and due to	the cause(s	s) and manner	as stated.	
e Hos	e Fun letely	Medical		niner: On the basis of exam and manner stated.									e(s)
Toth	Within To th comp	Me	29b. Signature and title of certifier	7			29c. Licen:	se number		29d. Da	ate signed (M	onth, Day, Year,)
,			1 Vull	ine	m	0	6	303	18	8	8/0-	2	
0 /	(5)		30. Name and address of person who								/		
L (Demetrios Jame 31. Date filed (Month, Day, Year)	es Catevenis, 32. Registrar's Si		Hospi	tal I	Orive,	Cheverly	, MD	20785		
	Sta Regist		THO .		-								
DHMH	17 Rev 1/2		2 0 2000	see &	fred	6							
						ORIGIN	AL						

08-06021 Amzie Lee Helms Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #8tate of Marchard / Proparting Interior Health and Mental Hygiene

2008 27581

		1- For State Registrar	er ri voos	Certific	cate of	Death				Re	g. No.	200	0 2100
Physic	ian/	Decedent's Name (First, Middle,	Last)							Date of Deat	h		3. Time of Death
al Exam		Amzie Lee Helm	ns						1	Month August 6,	Day Yo 2008	ear	1926 hrs
		4a. Facility Name (if not institution,	give street and number)		4	b. City, Tow	n, or Lo	ocation of [Death		4c. County		
		4608 Emerson Street				Hyattsvi	lle				Prince	George	's
Funeral		Social Security Number 6	Sex 7. Age	(In yrs. last bi	rthday)	If Under 1	Year	If Under 2	24Hrs. 8	B. Date of Bir	h(MM/DD/YY)	Y) 9. Birtl	hplace (State or North
Director		242-46-8042	4E-14 0 E-1	73	- V	Months	Days	Hours	Min.	11/0	1/1934	Foreigr	
			1 X M 2 F	7.5	Yrs.	<u></u>				1170	1/1754		^{intry)} Carolina
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town	n or Locatio	on							10d. Inside City Limits
*		,		•								l	1 X Yes 2 No
Maryland 28a-f show d at once	ğ	Maryland Prince	George's	нуат	tsvi1					- 1.	Og. Citizen of V	V5-1-0-11	
Mary 28a dat	Director	10e. Street and Number				10f. Zip Co				1			ury?
the 3a or	Ö	4608 Emerson S	treet				207	81			US		
72 hours after death with the Maryland n"matural", or items 23a or 28a-f sho al Examiner must be notified at once.	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		s Decedent of es, specify C				fy Yes or No		ce - Americ	can Indian, Black,
r death or ite	Į,	1 Never Married 2 X Marr	ried 1 X Yes 2	No	"16	es, specify o	uban, r	viexicali, i	dei to i tic	Jan, 616.)	****	•	ite
after al", c	by F	3 Widowed 4 Divor	ced If Yes, Give Year 10	51-1952	1	Yes 2 X	No	specify:			Specify	. WII	ıte
aturs	9	15. Decedent's Education (Specif	y only highest grade com	pleted) 16a		t's Usual Occost of working					16b. Kind of I	Business/Ir	ndustry
72 h n "n al E	ete	Elementary/Secondary (0-12)	College (1-4 or 5	i+)	during me	ost of working	j ilie. L	O NOT us	se retired)	Acme	Movi	ng
036 thin ne.	l g	12			Mo	oving	Spe	cial	ist		And S	Stora	ge
ed w ed w lygie other	Completed	17. Father's Name (First, Middle, L	•				18	3.Mother's	Name (Fi	irst, Middle, I	Maiden Surnan	ne)	
215 De fill Ital F Iked	Be	Winford A.	Helms					Cai	rmen	Lee E	udy		
MD 21215-0036 2 should be filed within th and Mental Bygiene. 27 is marked other tha umatic event, the Medic	ျ	19a. Informant's Name/Relationshi									nber, City or To		
AD 2 sh 27 is		Sarah Kathleen	Helms / Wif	е	4608	Emers	on	St.,	Hyat	ttsvil	le, MD,	2078	1
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after bepartment of Health and Mental Hygieral. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.		20a. Method of Disposition			of Disposi	ition (Name	of ceme	etery,	D	ate	20c. Location	n - City or	Town, State
ages nt of t: If		1 Bunial 2 X Cremation					ama 1	tory	08/12	4/2008	Alexar	ndria	, Virginia
Baltimor permit. Pages Department of Important: If		4 Donation 5 Other Spe 21. Signature of Puneral Service L		110010		ame and Ad			00/1-	+/ 2000			
Ba Depa Impo		21. Signature of different Screen	2					,	Home	РΔ	4/39 Hyatt	Balti	imore Ave. le, MD 20781
Dhysioian		235. Part I. Enter the disease, or co	omplications that caused	the death. Do r									Approximate Interval
hysician ^e Medical		failure. List only one cause o	n each line.				, 3.						Between Onset and Death
xaminerے	RO 0	Immediate Cause (Final disease or condition resulting in death)	a. Atherosclerotic		ular Dise	ease							
		or condition resulting in deduty	Due to (or as a conse	quence or):									
	e	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	quence of):									
	틀	Disease or injury that initiated	C.		_								
bs.	Examiner	events resulting in death) Last	Due to (or as a conse	quence of):									
itcate be executed g physician and the burial - transit	g	UNPENDED	d			<u> </u>							
O, e be e rsicia burial	ledical		Lucal Control of the								Too a Data	of delices	
68760, certificate bo nding physic se as the bun	Š	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcom	ne of pregnancy		tal death	3	Ectopic p	oregnanci	v	23d. Date Month		V Day Year
certi certi endin	cial	past 12 months?		time of death		ner (Specify		Lotopic	or ognane,	,	1		,
Box e death c the atten ed for us	Physicia	1 Yes 2 No 9 Unkn	own g Unknown		0	ici (open)							
t the		Part II. Other significant condition	ns contributing to death	but not resulti	ng in the u	nderlying ca	use giv	en in Part	1.	23e. Did to	obacco use co	ntribute to	the cause of death?
Division of Vital Records, P.O. Box 68 rate or Attending Physician: The law requires that the death certificate and Director: After this certificate has been signed by the attending led in by the funeral director, page 2 should be detached for use as	ğ	l),								1Ye	8 2 No	3 Prob	oably 4 🗹 Unknown
ds, equir een s	Completed									24a. Was			topsy findings available
taw r has b	횰	M								autor perfo	rmed?	prior to death?	completion of cause of
Re(The icate	5									1 Yes	2No	1 🗸 Ye	es 2 No
ian: certif	Be	25. Was case referred to medical examiner?	Ti			26.		of Death (C	Check onl	y one)			
Vithis I dire	٥	1 ✓ Yes 2 No	Hospital: 1 Inpatie		Outpatient		<u> </u>		Nursing I		Residence 6		r: Scene
1 of Jing Ph	<u>:</u>	27. Manner of Death	28a. Date of Inju (Month, Day,Ye	ry 28b ear)	. Time of Ir			at Work?		3d. Describe	how injury occ	urred	
On tendi	<u>≗</u>	1 Natural 5 Pendir 2 Accident Investi				1	Ye	es 2 N	No				
VISI or Att her d in by	į į	3 Suicide 6 Could	28e. Place of Ini	ury - At home,	farm, stree	et, factory, of	fice bui	ilding, etc.	28			nber or Ru	ıral Route Number, City
Divisior pital or Attencours after death erral Director; filled in by the	Certification:	4 Homicide determ								or Town, S	state)		
Hosp 24 ho Fune tely fi		29a. Certifier 1 Certifying Phy	sician: To the best of my	/ knowledge, d	eath occurr	red at the tin	ne, date	e and place	e, and du	e to the cau	se(s) and man	ner as stat	ed.
Division of Vital To the Hospital or Attending Physician; within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical	one) 2 • Medical Exam	iner:On the basis of exar	nination and/or	r investigati	ion, in my or	inion, (death occu	urred at th	ne time, date	and place, and	d due to th	e cause(s)
T I	₩	29b. Signature and title of certifier	/ A			29c. L	icense	number			29d. Date si	gned (Mo.	nth, Day, Year)
	1	MAL Pro	and AN	+			C.M	1.E.			August 7	, 2008	
0 (10)	1 8	30. Name and address of person w	ho completed cause of d) eath (Item 23a))					-	1	-	
(10)	4	Melissa Brassell, MD	Assistant Medical			enn Stree	et, Ba	altimore,	MD 21	1201			
s	tate	31. Date filed (Month, Day, Year)	32. Registra	s Signature	161								
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 1:10 **Physician** 2008 Valorie Anne Henry August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Lexington Park St. Bayside Care Center Mary's 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🖾 F 48 Yrs 508-60-9162 1959 Nebraska Director October 31, Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ed other than "natural", or items 23a or 28a-f show event, the Medical Examinar must be notified at Mechanicsville 1 ☐ Yes 21X No Director St. Mary's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 20659 26453 Tin Top School Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔣 No White Completed by If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than 'any injury or other traumatic event, train any injury or other traumatic event, trained any once. Elementary/Secondary (0-12) College (1-4or 5+) Sales Associate/Instructor Craft Store 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Hortense Anne Campbell James Ray Dickinson 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 411 Mechanicsville, MD 20659 Earl Allan Henry / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State August 27 Maryland Veteran's 2008 4 ☐ Donation 5 ☐ Other (Specify) Cheltenham, Maryland Cemetery 22. Name and Address of Facility 21. Signature of Funeral Spraic Licens Mattingley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 Approximate Interval Between Onset and Death 23a. Part I. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Duc to (or as a consequence of): Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 | Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Year Day 4 ☐ Pregnant at time of death 5 ☐ Other (specify) sbeen signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ♣No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 😕 Z No ours after death.

**reral Director: After this certific filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 □ Yes 2 □ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 ho

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completely f and manner stated. 29c. License number 46046 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 101 centerial st 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LIKHANI MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 008 For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) [□]6^y, 2008 August **Physician** 1:15 PM HALL MMA /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Summitt Park Nursing & Rehabilitation Catonsville If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 82 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 🖾 F 212-60-7443 Yrs. Director May 8, 1926 Marietta, NC Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 23a or 28e-f ehow other treumatic event, the Madical Examiner must be notified at 1 ☐ Yes 2 ☑ No MD Catonsville Baltimore Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1502 Frederick Road 21228 United States Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0036 1□Yes 2√√ No Specify: Black þ 3 Widowed 4 ☐ Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Domestic 9 other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Health and Mental Pages 1 and 2 should be Justin Hayes Dessie Dixon 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, MD 21217 Chris Hall (Son) 1512 North Appleton St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages
Department of H
Important: if Ite
any njury or of 1 Burial 2 □ Cremation 3 □ Removal from State Cedar Hill Cemetery 8/11/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fort Lincoln Funeral Home 3401 Bladensburg Road Brentwood, MD 20722 Kuhd pon 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury Examine or Attending Physicien: The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, the attending physician Completed by Physician/Medical as the IF FEMALE: **BS** 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 mooths?
1 □ Yes 2 □ 40 3 ☐ Ectopic pregnancy signed by the atte Month Year Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Winknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3□ DOA ဥ 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. thours after death.

Tuneral Director: A sit filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28I. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a Hospital 1 Certifying Physician: To the best of my knowledge, death conured at the time, date and place, and due to the causa(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick Rd. Coforgrille, 31. Date filed (Month, Day, Year) 32. Registrar's Sign State 2 2008 1 Registrar

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	/Meḋic Examin		4a. Facility Name (If not institution, g				4b. City, Tow	n, or Location of		uguoi		nty of Death	
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Z Mew D	nark	မှ	Wayne Gerard 19a, Informant's Name/Relationshi	Hughes		10h Mailir	na Addross /Si	reet and Numbe		Ellen Boute Number			in Code)
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Baltimore, bermit. Pages 1 ar Department of Hea	Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other treumatic event, it a Modical Exerciner must be rediffied at once.		21. Synature of uneral S	Densite				Figner En		*	Llion	coost	, MD 21795
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Baltimore, Maryland 21215-0036	Pages 1 and 2 should be tiled within 72 hours elter death with the Marylan nent of Heath and Mental Hygiene. Int. If Item 27 is marked other then "natural", or itema 23a or 28a-f ahow int. If them 27 is marked other than "natural", or itema 23a or 28a-f ahow int or other traumatic avent, the Madical Examinar must be notified at		20a. Method of Disposition 1 XBurial 2 Crema	ation 3 □Re		20b. F	cemetery, cri Lak	oosition (Name of ematory of other emont	place)	Date		20c. Location			
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	/Medic	al	Lucretia Holbrod						Aug	ust 9	2	800	6:15	p M
	Examin	er	4a. Facility Name (If not institution		hab O		4b. City, Town, o		Death	4	c. County			
	Funeral		Manokin Manor 5. Social Security Number	6. Sex 7. Age	ellab. C e (In yrs. last		Princess If Under 1 Year	If Under 2	24 Hrs. 8. Date	of Birth		merse 9. Birthpl	ace (State o. try)	r Foreign
	Director		215-26-2627	1□M 20XF	100	Yrs.	Months Days	Hours	June June	21, 19	808	Maryl	and	
	land		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	own or Lo	cation					10	d. Inside Cit	ty Limits
	Mary -f sho	ţō	Maryland Somer	set	Pri	incess	Anne						1 🗌 Yes	2 📉 No
	or 28e	Directo	10e. Street and Number				10f. Zip Code	-		10g. C	itizen of W	Vhat Coun	try?	
	72 hours after death with the Maryland natural, or items 23e or 28e-f show dical Exportree must be notified at	rai	11974 Edgehill				2185				USA			
	items items	Funerai	11. Marital Status 1 □ Never Married 2 □ Marri	12. Was Decedent for Armed Forces? ied 1 ☐ Yes 2 📉 N		13. V	Vas Decedent of H f Yes, specify Cuba	lispanic Orig an, Mexican,	in? (Specify Yes Puerto Rican, et	or No- c.)		e - Americ k, White, e		
020	urs aff	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	40	1	!□Yes 2KINo	Specify:			Specify	Black	ζ	
2-002d	72 ho	Completed	15. Decedent (Specify only highes	's Education	11	6a. Deced	lent's Usual Occup	ation	of working	16b.	Kind of Bu			
7	ne. han	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)		kind of work done OO NOT use retired	d)	or working	He	otel/N	Motel		
V	Hygie Hygie ther t	e Co	8th 17. Father's Name (First, Middle, I	Last)		Chef		18. Mother	's Name (First, A	Aiddle Maide	n Sumam	e)		
מום	ld be ental ked o	To Be	Charlie		olbroo	k		Sall		, , , , , , , , , , , , , , , , , , , ,		Hitc	h	
ary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or items 23e or 28e-f show any injury or other traumetic avent, the Medical Expiriting must be notified at once.	-	19a. Informant's Name/Relationsh	nip (Type, Print)	1	19b. Mailin	g Address (Street	and Number	r or Rural Route I	Number, City	or Town,	State, Zip	Code)	
e E	and 2 ealth m 27 i		Geraldine Jones/s	ister	1	1121	St. Agnes	Lane						
	ges 1 if of H if ital		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 ☐Removal from State	-		sition (Name of natory or other place	i	Date	20c.	Location -	City or To	wn, State	
Dallillor	it. Pa irtmen irtant: njury		'4 □Donation 5 □Other (Sp 21. Signature of Funeral Service)		Trinit	yC.W.	C.Cemete	ry 8	/16/2008	Prin	cess	Anne	MD	(D)
0	permi Depa impo any ir		A Thine	CA LADE	0.1		. Name and Addre							41)
	-		23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caused	the reath. D		${ m DLLEY}$ MF ar the mode of dyin				Α.	218	Approximate Interval Bety	3
	Physician :		Immediate Cause (Final disease or condition	only one cause on each in		EMI						- V	Onset and D	Death
	/Medical Examiner		resulting in death)	Due to (or as a	-								4 110	7
	100	<u></u>	Sequentially list conditions,	b. Due to (or as a	a consequen	co off:								
Т	nted Insit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (61 as a	a consequent	ce oij.								
Š	be executed ician and burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a	consequence	ce of):								
000	icate be executed physician and s the burial-transit	dical		d							-			
ŏ	entifica ding pl	ě	IF FEMALE:	222 15 122 21 122	-6									
200	The law requires that the death certific the has been signed by the attending p. page 2 should be detached for use as I.	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth	2 🗌 Fetal dea	ath 3 🗌	Ectopic pregnancy Other (specify)	,			23d. Date Mor	e of delive ath	-	'ear
į	t the d by the ached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown										
'n	es tha gned	by P	Part II. Other significant condition	ns contributing to death bu	ıt not resultin	g in the un	derlying cause give	en in Part I.	23e.	Did tobacco	use contr	ibute to th	e cause of de	eath?
2	een si						<u> </u>			1 Yes	2 🗖 No	3 Proba	ably 4 □U	inknown
ט ע	has b	Completed							24a.	Was an autopsy	P	rior to con	sy findings a pletion of ca	ivailable ause of
	ilcien; The lav certificate has rector, page 2		05.11						1 🗆	performed? Yes 2 K		eath?	2□ No	
2	Physicien; this certific ral director,	To Be	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	ot 2 🗆 EB/	Outpatient	t 3□ DOA Oth	or /	of Death (Check		c 🗆 🗆	(C t		
VII	a Phy eral c			i 🗀 iripatioi	n ZLIEN	b. Time of			sing Home 5	cribe how inj			,	
5		-	27. Many er of Death	28a. Date of Injur	y 28t	D. Tante Of	28c. Injun	y ar	200. Des		,	ed		
5	ending sath. or; Aft he fun	ation	1 Natural 5 ☐ Pending investig	ation (Month, Day	Year) 28t	Injury	Worl	yat k? Yes 2 □ N		,	,	ed		
5	or Attending ifter death. Diractor; Aft. in by the fun	rtification	1 Natural 5 ☐ Pending	ation ot be	Year)	Injury	M 1	k?	28f. Loca	tion (Street a	and Numbe		Route Numl	ber,
5	pital or Attending ours after death. eral Diractor: After filled in by the fun	il Certification;	1 Natural 5 Pending investig 3 Suicide 4 Homicide 6 Could n	(Month, Day ation ot be ned 28e. Place of Inju building, etc	ry - At home, (Specify)	Injury , farm, stre	M 1 D	k? Yes 2 □ N	28f. Loca	tion (Street a or Town, Sta	and Numberte)	ər or Rurai		ber,
5	e Hospital or Attending 124 hours after death. The Funeral Diractor; After Hetely filled in by the funeral	O	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier 5 Pendin, investig 6 Could n determi	ation of be 28e. Place of Inju	ry - At home, . (Specify) of my knowled examination	Injury, farm, stre	M 1 Deet, factory, office	k? Yes 2 □ N	28f. Loca City	tion (Street a	and Number te)	er or Rurai	ated.	
5	he Hospita n 24 hours he Funeral pletely filled	Medical Certification	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier	ation ot be ned 28e. Place of Injubulding, etc	ry - At home, . (Specify) of my knowled examination	Injury, farm, stre	M 1 cet, factory, office occurred at the time estigation, in my of	k? Yes 2 N ne, date and pinion, death	28f. Loca City	tion (Street a or Town, Sta o the cause(time, date a	and Number te)	er or Rural	ited. the cause(s)	
5	To the Hospital or Attending within 24 hours after death. To the Funeral Diractor: Aft completely filled in by the fun	edical C	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier U.S. Notation	gation ot be ned 28e. Place of Injubuilding, etc g Physician: To the best of Exeminer: On the basis of and manner sta	iny - At home, . (Specify) of my knowled examination	Injury , farm, stre dge, death and/or inv	M 1 Deet, factory, office occurred at the time estigation, in my of 29c. License	k? Yes 2 N ne, date and pinion, death	28f. Loca City place, and due to n occurred at the	tion (Street a or Town, Sta o the cause time, date an	and Number te) s) and maind place, a	or or Rural nner as stand due to	ated. the cause(s) Day, Year))
5	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	edical C	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier U.S. Name and addless of person v.	g Alion of the ned 28e. Place of Injuniding, etc building, etc exeminer: On the basis of and manner sta	iry - At home, . (Specify) of my knowled examination ted.	Injury , farm, stre dge, death and/or inv	M 1 Deet, factory, office occurred at the time estigation, in my of 29c. License	k? Yes 2 N ne, date and pinion, death	28f. Loca City place, and due to n occurred at the	tion (Street a or Town, Sta o the cause time, date an	and Number te) s) and maind place, a	or or Rural nner as stand due to	ated. the cause(s) Day, Year))
5	To the Hospital or Attending within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	Medical C	1 Natural 2 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one) 29b. Signature and title of certifier U.S. Name and address of person of the control of the control of the certifier D.R. U.S. HA NAT	28e. Place of Injubuilding, etc g Physician: To the best of Exeminer: On the basis of and manner sta	iny - At home, . (Specify) of my knowled examination	Injury , farm, stre dge, death and/or inv	M 1 1 2 set, factory, office occurred at the time estigation, in my of 29c. License D 0	k? Yes 2 N ne, date and pinion, death	28f. Loca City	tion (Street a or Town, Sta o the cause time, date an	and Number te) s) and maind place, a	or or Rural nner as stand due to	ated. the cause(s) Day, Year))

DHMH 17 Rev 1/2001

Lucretig Harris august 09,2008 625

		4	For State Registrar	State	of Marylan		artment <i>rtificate</i>			ınd Me	ntal Hyو ا	giene Reg. No.	2008	27587
п	LIE I	Ŋű.	1. Decedent's Name (First, Middle	, Last)						2	Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic	_	Ada Mae Jenki	ns						Αι	igust			9:55AM⊓
	Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, To	own, or	Location o	f Death		4c.	County of Death	_
			Manor Care Nurs		17.4 //		Large If Under 1		If Under 2	24 Hrs. I n	Date of Bird		ince Geo	
	Funeral			6. Sex 1 ☐ M 2 🛣 F	7. Age (In yrs.	last birthday) Yrs.		Days	Hours	Min.	Date of Birt (Month, Da	n y, Year)	Cour	
H	Director	F	578-28-9317 Usual Residence of Decedent		95					3,	/28/19	13	Red S	Springs,NC
	/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation						1	0d. Inside City Limits
	Man a-f sh ifled	흕	Maryland Prince	George'	s Sui	tland_								1x Yes 2 No
	or 28	Director	10e. Street and Number				10f. Zip C	Code				10g. Citiz	zen of What Cour	ntry?
	th wil	<u> </u>	3206 Lassie Ave	•			20	0746					ted Stat	
	r dea	Funeral	11. Marital Status	Armed I		.S. 13.	Was Decede If Yes, specif	ent of His ify Cubar	spanic Orig n, Mexican	gin? (Specit i, Puerto Ri	fy Yes or No can, etc.)	- '	 Race - Americ Black, White, 	
20	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notifiled at	by Fi	1 ☐ Never Married 2 ☐ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 ☐ Yes If Yes, 0 Year or	s 2 ☑ No Give		1 □ Yes 2	No No	Specify:				Specify: Bla	ick
Ş	should be filed within 72 hours after death with the Marylan nd Mental Hyglene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23a or 28a-f show imatic event, the Merikal Examiner must be notified at	pa	15. Decedent		Dates.	16a. Dece	dent's Usual	Occupa	tion			16b. Kii	nd of Business/In	dustry
Ċ	in 72 n "na Nectic	Completed	(Specify only highes Elementary/Secondary (0-12)	st grade completed	-	(Give	kind of work DO NOT use	k done di	uring most	t of working				,
7.17	yiene jiene r thai	E O	12	College	(1-4or 5+)	 Hotel	Maid					Pri	vate Ind	lustry
פַ	e filed within 72 h al Hygiene. I other than "natu vent, the Merica	Be C	17. Father's Name (First, Middle,	Last)					18. Mothe	r's Name (i	First, Middle,	Maiden	Surname)	
<u>a</u>	uld b Wenta rrked ric e	70 E	Jim Shields						Tin	У				
Maryland 21215-0036	es 1 and 2 should to Health and Meni of Health and Meni fitem 27 is marked rother traumatice		19a. Informant's Name/Relationsl	nip (Type. Print)		19b. Mailii	ng Address ((Street a	nd Numbe	er or Rural i	Route Numb	er, City o	r Town, State, Zip	Code)
	and ealth m 27		Dorine M. Adams	/ Friend									nd 20746	
Baltimore,	Pages 1 nent of H int: If Ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 ☐Removal from	m State	Place of Dispo cemetery, cre	matory or oth	e or her place	1	Dat			cation - City or To	.,
E			4 □ Donation 5 □ Other (S		Ro	ck Cre				8/15/			ington,	
ga	permit. Departr Importa any Inj		21. Signature of Funeral Service	1	170100	4				_			Homes, P	
	. 0		23a. Partti. Enter the disease, or	complications that									e, Mary	and 20747 Approximate
			23a. Partt. Frier the disease, or shock, or heart failure. List Immediate Cause (Final						,, 00011 00	ourgius or	. Sopilatory a	,,		Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)	d	GESTIVE I		FAILUR	₹Е						
	Examiner				DIOMYOPA'									
Š		ē	Sequentially list conditions, if any, leading to immediate		o (or as a consec									
	uted d ansit	Examiner	d any, leading to miniediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	COR	ONARY AR'	TERY D	ISEASE	Ξ						
o,	an an rial-tr		resulting in death) Last	Due t	o (or as a consec	uence of):								
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and toge 2 should be detached for use as the burial-transit	dical		d										
9	ng ph	Med	IF FEMALE:									1		C0111
် က	leath certifi attending for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1 ☐ Liv	outcome pf pregn e birth 2 Feta	al death 3	⊒Ectopic pre					11	23d. Date of deliv Month	rery Day Year
<u>.</u>	ie des the a	sici	1 ☐ Yes 24 TXNo 9 ☐ Unknown	4∐Pre 9□Un	egnant at time of o known	death 5[Other (spe	ecify)						
<u> </u>	w requires that the d been signed by the should be detached		Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	ınderlying ca	use give	en in Part I		23e. Did	tobacco u	ise contribute to	the cause of death?
ds,	signe d be	l by	•	3		,	,	J			10	Yes 2	□ No 3□ Pro	bably 4XUnknown
S	v requ	Completed									24a. Was	an	24h Were aut	opsy findings available
æ	he lav has ge 2 :	ldm									auto	psy ormed?	prior to co	ompletion of cause of
Vital Records, P.O. Box			25. Was case referred to medica						Of Diagram	of Dooth	1□ Yes Check only	2 X No	1 □ Yes	2□ No
5	ding Physician: The lar. After this certificate has funeral director, page 2	o Be	examiner? 1 Yes 2X No	Hospital:	☐ Inpatient 2 ☐] ER/Outpatie	nt 3□ DO/	A Othe	or.				6 □Other (Spec	if(z)
0	g Phy er this eral c	n: To	27. Manner of Death	28a. Da	te of Injury	28b. Time o		8c. Injun			d. Describe			(4)
0	ath. r: Aft	aţjo	1 X Natural 5 ☐ Pendin 2 ☐ Accident investi	gation	onth, Day Year)	Injury	M		ves 2 □	No				
Division or	I or Attending I after death. Director: After I in by the funer	iffic	3 Suicide 6 Could 4 Homicide determ	ined Zoe. Pic	ace of injury - At h	ome, farm, st	reet, factory,	, office		28	If. Location (ral Route Number,
	pital or Attenions after deathers after deatheral Director: filled in by the	Certification:												
	Hosp 4 hou Fune iely fil	ical	(Check only 2 Medical	ng Physician: To Examinar: On the	e basis of examin									
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific: completely filled in by the funeral director,	Medical	one) 29b. Signature and title of certifie		anner stated.		29c	. License	e number			29d. Da	te signed (Month	. Day. Year)
	7.½ 7.8		i i	()										
	(0)		30. Name and address of person	who completed a	ause of death (Ita	m 23a) (Tue-		5152	20			Aug	gust 12,	2008
1	(4)		Bahram Pishdad		28 South			I. Si	iite	310 W	ashing	gton.	D.C. 20	0032
	St	ate	31. Date filed (Month, Day, Year)	32	. Registrar's Sign	ature				• "				
	Regist		AUG 1 4 20	08) K	frau	63							

			For State	State	of Marylan		artment of H		Menta		2.0	กล	27	588
-			Registrar 1. Decedent's Name (First, Middle, Las	et)		Cei	lineate of L	Jean	2. Date	e of Death	. No. 4 U	00	3. Time of	
	Physici	an	5	,	T = %				Mon	ith	Day	Year		M
	/Medic		4a. Facility Name (If not institution, give	nn	Johnson	L	4b. City, Town, or	Location of Des	Aug	ust	11 20 4c. County of	08	4:25	Α "
Sale .	Examin	er											•	
			5822 Corporal Jon 5. Social Security Number 6. S		7. Age (In yrs. i	last hirthday)	Mt. If Under 1 Year	Airy If Under 24 Hr	s. 8 Date	of Birth	Fred		k lace (State o	r Foreian
	Funeral Director		1	M 2 🔀 F		Yrs.	Months Days	Hours Mir	1. (Mol	16		Coui	ntry)	
0			213-56-8215 Usual Residence of Decedent		58				pury	10,	1930	wası	ingtor	1, DC
	land ow at		10a. State 10b. County		10c, City	y, Town or Lo	cation		-				l0d, Inside Ci	ty Limits
	Mary fsh led a	ō	Maryland Freder:	ick		Mt. A	irv						1 ☐ Yes	2⊠No
	the 28a notif	Director	10e. Street and Number	LCK		116. 11	10f. Zip Code			10g	. Citizen of W	/hat Coul	ntry?	
	with yell		5822 Corporal Jo	nes Co	urt		217	771			Unite	4 C+	atos	
	ns 2%	Funeral	11. Marital Status	12, Was De	cedent Ever in U.	S. 13. V			Specify Yes	or No-	14. Race	- Americ	can Indian,	
	ter d	ᇤ	1 □ Never Married 2 ☑ Married	Armed F	orces? 2 ☑ No		Was Decedent of Hi If Yes, specify Cuba	an, Mexican, Puè	rto Rićan, e	etc.)	Black	k, White,		
36	irs al	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, G Year or I	live		1 □ Yes 2⊠ No	Specify:			Specify.		Thite	
21215-0036	2 hou	ted	15. Decedent's Ed	lucation		16a. Dece	dent's Usual Occup	ation		16	b. Kind of Bu	siness/In	dustry	
5	n "n n "n Medi	ple	(Specify only highest gra) (1-4or 5+)	(Give life. I	kind of work done on DO NOT use retired	during most of w d)	orking					
7	with jiene r tha	Completed	12	College	(1-401 5+)	Pro	ject Mana	ager			Commu	nica	tion	
ō	othe ent,	Be C	17. Father's Name (First, Middle, Last)					18. Mother's Na	ame (First,	Middle, Ma	iden Surnam	e)		-
Baltimore, Maryland	lid be lenta rked ic ev	To B	Anthony Catena					Ann C	aruso					
37	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street				City or Town,	State, Zij	Code)	
Š	h a ra		David L. Johnson	/ Husb	and	5822	Corporal	Jones C	ourt	Mt.	Airv.	Marv	land 2	1771
ā,	s 1 and 2 f Health Item 27 I		20a. Method of Disposition	,			sition (Name of matory or other place	, [Date	20	c. Location -			17/1
2	ages ant of t; If I		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification 2)		State			ı Au	gust 200	12,	م ما ما	_1_	M1 -	1
≟	artme artme ortan Injur	H	21. Signatur, of Fun ral Service Licen		bla		Crematory Name and Address				rederi	CK,	магута	.na
Ba	permit. Pages 1 and Department of Healt Important; If Item 2' any Injury or other once.			1) 1		8	2. Name and Addres E. Ridgev	71110 R1	tauiie wd	er rui M+ A	neral I	Home	s, P.A	• 771
	_	\vdash	23a Part1 Enter the disease or com	plications that	caused the deat							aryı		
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final									Approximat Interval Bet Onset and	ween Death			
	Physician		disease or condition resulting in death)	а.	rcinosar									
	/Medical Examiner		resulting in dealing	Due to	o (or as a consequ	uence of):								
ĸ.	Lxammor	L	Sequentially list conditions,	b								_		
	od sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause Juleage or injury that initiated events	Due to	o (or as a consequ	uence or):								
	ecute and -tran	cam	that initiated events resulting in death) Last	C	o (or as a consequ	uanac afti								
9	The law requires that the death certificate be executed ate has been signed by the attending physician and bagge 2 should be detached for use as the burial-transit	Ω =		Due to	(or as a consequ	uence or).								
8760,	ate thysic	dical		d										
မ	entific ing p	Med	IF FEMALE:								1			
Box	eath certific attending p for use as	an/	23b. Was decedent pregnant in the past 12 months?		utcome pf pregna birth 2 ☐ Feta]Ectopic pregnancy	/			23d. Dat			Year
<u>.</u>	he a	sici	1 ☐ Yes 2 🔀 No	4∐Pre∉ 9∐Unk	gnant at time of d nown	eath 5	Other (specify)						Duy	7 0 41
Vital Records, P.O.	that the de ned by the a detached t	Physician/Me	9 Unknown		al a a bla ta a d a a a d a a a a	. Was to the s	and and other and a second	anda Banki	20.	- Did toba		db	h	de este O
Ś	res tha igned be def	þ	Part II. Other significant conditions of	ontributing to	death but not resi	uiting in the u	nderlying cause give	en in Paπ i.	230		cco use conti			
b	w requir been si should b								-	1 ∐ Yes	2 🔀 No	3∐ Pro	bably 4 🔲	Unknown
ပ္ပ	law r as be 2 sh	ple							24	a. Was an autopsy	24b. \	Vere aut	opsy findings impletion of c	available
œ	sIcian; The law certificate has t irector, page 2 s	Completed							1	performe	ed? c	leath?	2 ⊠ No	
<u>ta</u>	lan; rtifica tor, p	a	25. Was case referred to medical					26. Place of D			2110		- 20	
>	yslc is ce direc	O B	examiner? 1 ☐ Yes 2 ☎ No	Hospital: 1 □	Inpatient 2	ER/Outpatier	nt 3□ DOA Oth	er: 4 \(\sum \) Nursing	Home 5	X Residen	ce 6 □Oth	er <i>(Speci</i>	fy)	
Division or	g Ph ter th neral	L I	27. Manner of Death		e of Injury onth, Day Year)	28b. Time o Injury	f 28c. Injur Worl	y at	28d. De	scribe how	injury occurr	ed		
Ö	rth. rt: Aff	atio	1 Natural 5 Pending 2 Accident investigation		illii, Day Tear)	injury		Yes 2 □ No						
<u> </u>	Atte	iii ci	3 Suicide 6 Could not be determined	20e. Flat	be of injury - At ho ding, etc. (Specif	ome, farm, str	reet, factory, office		28f. Loc	ation (Stre	et and Numb	er or Rur	al Route Nun	nber,
Ö	al or s afte	Certification:	T LITOTHOIGE	l buil	umg, etc. (opcon	<i>y</i> /			0.15	or rown,	State)			
	splt hours mera y fille						h occurred at the tir							,
	e Ho Pe Fu	Medical	(Check only 2 Medical Exar		basis of examina inner stated.	ttion and/or in	vestigation, in my o	opinion, death oc	curred at tr	ie time, dat	e and place,	and due	to the cause(S)
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Me	29b. Signature and title of certifier	7.	1 11.		29c. Licens	e number		290	d. Date signed	d (Month	Day, Year)	
) / //	1/1/	V	ヘリ	D53	177			August	: 12.	2008	
,	5		30. Name and address of person who	completed car	use of death (Item	n 23a) (Type.								
	15		John Wallmark,				Center Dr	ive Roo	kvi11	e. Ma	rvland	1 208	350	
	Sta	ite	51 5 1 10 1 10 1 10 5 11 10 10 10 10 10 10 10 10 10 10 10 10	1 00	D:			1.00		,				
	Registi	-	AUG 1	2010	Registrar's Signa	, Di.	HOWEL							

08-06030 Ira Stephen Kaye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 27589

		Registrar	Certificate of D			Reg.		00 213		
Physicia al Exami		Decedent's Name (First, Middle,Last) Ira Stephen Kaye				2. Date of Death Month E August 7, 20	Day Year	3. Time of Death 0740 hrs		
		4a. Facility Name (if not institution, give street and number)	4b.	City, Town, or Lo	ocation of Death	August 1, 2	4c. County of Dea	th		
		326 Oak Knoll Drive	F	Rockville			Montgomery			
Funeral Director		144-50-1456 1XM 2_F	yrs. last birthday) 45 Yrs.	Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth Apr. 22	` 1 C	irthplace (State or Foreign country) Iew Jersey		
w any		Usual Residence of Decedent 10a. State 10b. County 10c	. City, Town or Location					10d. Inside City Limits		
land f shov	to		Rockville			- 1.0		1 X Yes 2 No		
r 28a-	Director	10e. Street and Number	1	Of. Zip Code		100	. Citizen of What Co	untry?		
ith the s 23a c		326 Oak Knoll Drive 11. Marital Status 12. Was Decedent Eve	rin U.S. 13. Was I	20850 Decedent of Hispa		ecify Yes or No-	U.S.A.	erican Indian, Black,		
leath v	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X	If Yes,	, specify Cuban, I			White, etc.			
after o	by F	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 Y	es 2 X No			Specify: Wh:			
hours 'natur Exam		15. Decedent's Education (Specify only highest grade complet Elementary/Secondary (0-12) College (1-4 or 5+)		Usual Occupation to of working life. If			16b. Kind of Busines	s/Industry		
36 thin 72 than than edical	Completed	Liemantaly/Secondary (0-12)	Attori	nev			Law			
215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica		17. Father's Name (First, Middle, Last)		-	3. Mother's Name	(First, Middle, Ma	aiden Surname)			
2121 Ould be fi Mental marked c event,) Be	Jerome Kaye 19a. Informant's Name/Relationship (Type, Print)	19h Mailing A	ddross /Street		e Mendel	OWITZ per, City or Town, Sta	ate Zin Code)		
MD 2 id 2 shou ilth and h in 27 is n aumatic	To	Michael Lacey - Partner		,			e, MD 208			
e, N 1 and 1 and Health item		20a. Method of Disposition	20b. Place of Disposition	on (Name of ceme			20c. Location - City			
MOI Pages rent of nut: If		1 Bunal 2 X Cremation 3 X Removal from State 4 Donation 5 Other Specify:	National Cr	ematory	8/1			rch, Virginia		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Nar Danz	ne and Address Cansky-G	of Facility oldberg	Memoria	l Chapels ille, MD	Inc.		
hysician		23a. Part I. Enter the disease, or complications that caused the	death. Do not enter the	mode of dying, s	uch as cardiac o	r respiratory arres	st, shock, or heart	Approximate Interval		
Medical ⊆xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Compressional As	phyxia					Between Onset and Death		
LXammer		or condition resulting in death) Due to (or as a consequence)	ence of):							
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	ence of):				 .			
nted d ansit	Examiner									
760, reate be executed sphysician and the burial - transit	Medical	UNPENDED AMENDED								
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	sician	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Feta	I death 3	Ectopic pregna	ancy	23d. Date of deliv Month	rery Day Year		
P.O. B ss that the d gned by the e detached	"-		ut not resulting in the un-	derlying cause gr	ven in Part I.			to the cause of death?		
S, P uires th n signe Id be d	ed by							Probably 4 Unknown		
Division of Vital Records, P.(Island Attending Physician: The law requires that its after death. In Director: After this certificate has been signed led in by the funeral director, page 2 should be deta	Completed					24a. Was a autops perform	sy prior death			
cian:	Be C	25. Was case referred to medical examiner? Hospital:		- 1	of Death (Check					
of Vi ng Physi After this	은	1 Yes 2 No Inspired 1 Inpatient 27. Manner of Death 28a. Date of Injury	2 ER/Outpatient		y at Work?		Residence 6 🗹 Of	ther: Scene		
ion of tending eath. tor: Aft	tion:	1 Natural 5 Pending Aug 7, 2008			es 2 🗸 No		pressed between	en two autos		
Division pital or Attoours after de leral Directe filled in by t	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify) Other	/ - At home, farm, street, (specify)	, factory, office bu	uilding, etc.	or Town, St		Rural Route Number, City		
To the Hospita within 24 hours To the Funeral completely fille	edical C	29a. Certifier 1 Certifying Physician: To the best of my kr (Check only one) 2 Medical Examiner: On the basis of examin	nowledge, death occurre	ed at the time, dai	te and place, and death occurred	d due to the cause at the time, date a	e(s) and manner as s and place, and due to	stated. the cause(s)		
To the within To the comple	Med	and manner stated. 29b. Signature and title of certifier		29c. License			29d. Date signed (
25		Do m Jink IMB		O.C.N	И.E.		August 7, 200	8		
		30. Name and address of person who completed cause of deal	,	Donn Chrost	Dolting *	ID 24204				
		Donna M. Vincenti, MD Assistant Medical 31. Date filed (Month, Day, Year) AUG 132 32 Registrar's		Penn Street,	baitimore, N	1U 21201	-			
S Regis	tate	AUG 12 2008		The state of the s						

		State of Maryland / Departm			ental Hyg	jiene	008 2759	ın
		negisuai	cate of L	Death		eg. No. 🚄		U
Physicia	ın '	1. Decedent's Name (First, Middle, Last)			2. Date of Dea Month	th Pay	Year 9:27 QN	
/Medic	al	Sheila Hoskins Kenney	City Town or	Location of Death	lugust	4c. County	W8 0.71	-
Examino	er	4a. Facility Name (If not institution, give street and number) 4b. Civista Medical Center	La La	Plata		4c. County	barles	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If U	Jnder 1 Year	If Under 24 Hrs.	8. Date of Birth	, Vaarl	Birthplace (State or Foreign	gn
Director		219–27–5173 73 Yrs.	nths Days	Hours Min.	May 14,	1935	Scotland	
and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location	n				10d. Inside City Limit	ts
Maryla f sho	ō	Maryland Charles Waldorf					1 □Yes 2 ▼N	lo
r 28a	Director	10171111	f. Zip Code			I0g. Citizen of	What Country?	
h with		4085 Ben Ledi Place	2060	1		United	Kingdom	
DESILITION FOR WAITY ISLESS TO SOLVE THE RESILIES OF THE MATCHING PERMIT. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. The mortant: If then 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Evancial court to retition and once.	by Funeral	Armed Forces? If Yes,	Decedent of Hi s, specify Cuba es 2 X No	spanic Origin? (Spe n, Mexican, Puerto f Specify:	cify Yes or No- Rican, etc.)		ce - American Indian, ick, White, etc. White	
72 ho	etec	15. Decedent's Education 16a. Decedent's (Specify only highest grade completed) (Give kind of Give kind of Gi	s Usual Occupa	ation furing most of workir ')	ng l	16b. Kind of B	Business/Industry	
/ithin in i	Completed	Elementary/Secondary (0-12) College (1-4or 5+))		At Hon	ne	
Hygie ther ther ther		12 Homemak 17. Father's Name (First, Middle, Last)	CEI	18. Mother's Name	(First, Middle,			
id be file lental H ked oth ic even	To Be	James Hagg		Isabella	Robbie			
ind 2 shou alth and N 27 is mai er traumal		19a. Informant's Name/Relationship (Type. Print) James Kenney/Husband 19b. Mailing Add 4085 Be	dress (Street a	and Number or Rura Place, W	aldorf,	r, City or Town	n, State, Zip Code) 501	
diffinore, mit. Pages 1 a partment of He portant: If item y injury or othe		20a. Method of Disposition 1 □ Burial 2 □ ★Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	y or other plac E chols	Crem. Aug	ate 20, 2008	Char	- City or Town, State Lotte Hall, MD	
Dalt permit. Departm Importa any inju		21. Signature of Funeral Service Licensee	me and Addres	ss of Facility Br1	nsfield	-Echol: rlotte	s F.H., P.A., Hall, MD 2062	2
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the	e mode of dyin	g, such as cardiac o	r respiratory ar	rest,	Approximate Interval Between	
Physician		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Way After Cause (Final disease or condition)	Led	Canla	~		Onset and Death	
/Medical Examiner		resulting in death) Due to (or as a consequence of):	V /		-			
ed sit	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events						
icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last C		<u>.</u>				
6 / 6U, cate be exphysician the burial	dical	d						
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DIVISION OF VITAI RECORDS, F.O. BOX of the Hospital or Attending Physician: The law requires that the death certificating the Yours after death. To the Funeral Director. After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as	Physician/Me		topic pregnanc ner (specify)	у			ate of delivery Ionth Day Year	
s that s that med b	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underly	ying cause give	en in Part I.	23e. Did to	obacco use co	ntribute to the cause of death?	
equire	ed b	1 runs rig			12(′es 2□No	3 Probably 4 Unknow	Νn
II KECOLGS, The law requires the cate has been signe page 2 should be o	Completed	Chronic Obstructivi Palas,	nar)	ا ديو يه	24a. Was autop perfo 1 ☐ Yes		. Were autopsy findings availab prior to completion of cause o death? 1 ☐ Yes 2 ☐ No	ole of
VITAI iclan: T certificat ector, pa	Be	25. Was case referred to medical examiner?	Oth	26. Place of Death	(Check only o	ne)		
Phys r this rral dir	٠ <u>۲</u>	1 ☐ Yes 2 No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of		4 🗀 Nursing Ho	me 5 Resident			
On ding h. After	tion	1 Natural 5 Pending (Month, Day, Year) Injury	28c. Injur Worl	k? Yes 2 □No	zou. Describe r	low injury occu	ined	
LIVISION I or Attending after death. Director: After din by the fune	Certification:	3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, fi building, etc. (Specify)	factory, office		28f. Location (\$ City or Tov	Street and Nun vn, State)	nber or Rural Route Number,	
Hospita 24 hours Funeral etely filled	Medical C	29a. Certifier (Check only one) 1 Certifying Physionan: To the best of my knowledge, death occ 2 Medical Examiner On the basis of examination and/or investigand manner stated.						
To the within To the compl	Me	29b. Signature and title of certifier	29c. Licens	e number		_	ned (Month, Day, Year)	
20		13 5 1 m	D-3	33426		8-1	9-08	
20		30. Name and address of person who completed cause of death (Item 23a) (Type, Print	00 0	20× 2015				
Sta Registr		31. Date filed (Month, Day, Year) 32. Legistrar's Signature	B)	en aldos	Lark	ita, M	D 20646	
11091011		MAK A T						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AUGUST 2008 3:40AM M MARY ELIZABETH KENNEDY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON WILLIAM HILL GARDENS 8. Date of Birth (Month, Day, Y If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) **920** Days Hours Min 1 □ M 2 🛣 F 87 MARYLAND Director 219-03-5992 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show an "natural", or Items 23a or 28a-f shov Medical Examiner must be notified at 1 Yes 2 No Director MD TALBOT EASTON 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21601 545 CYNWOOD DR. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo Specify: WHITE ģ 3 Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) filed within Hygiene. than Elementary/Secondary (0-12) College (1-4or 5+) the OWN HOME HOMEMAKER 10 is marked other permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be JOHN FOSTER ELIZABETH DYOTT ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAMMY K. MILLER/DAUGHTER 29822 GRASSWELL ROAD, EASTON, MARYLAND 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) SPRING HILL CEMETERY 8/14/2008 EASTON, MARYLAND 21. Signature of Funeral Service Licensee 22 Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 CAHOI MERCERON 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** -ailyse /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine certificate be executed burial-transit 14 cm 50 and Due to (or as a consequence of) physician Physician/Medical the IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 Yes 2 🗆 M 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ASSISTED 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ဥ this LIVING funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu death. investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

TLS

Maryland 21215-0036

altimore.

Box 68760

P.O.

Records.

Division or Vital

Registrar

Medical

31. Date filed (Month, Day, Year)

AUG 1 3 2008

29b. Signature and title of certifier

29a. Certifier

(Check only

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

8-11-08

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 592 State Registra AMEND#18perFH 8-15-08, BMW, MpCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Day **Physician** 8:40 а.м Celeste I. Aug. 8, 2008 Lozupone /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Spring House Battery Lane Bethesda Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 X F 85 Director Apr.23, 1923 Washington, DC 577-24-0756 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at 1x Yes 2 □ No Director Md. Montgomery Bethesda 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 4925 Battery Lane 20814 USA #301 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 27 is marked other than traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Administrative Assistant U.S. Government 18. Mother's Name (First, Middle, Maiden Surname)
Bonucelli 17. Father's Name (First, Middle, Last) Be and 2 should be f lealth and Mental I Frank Paul Lozupone Mary Anne Bonnuce III P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any Injury or other tray Rita L. Cardillo/Sister 4515 Willard Ave., #510, Chevy Chase, Md. 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Aug.13,08 Ft. Lincoln Cem. Brentwood, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility DeVol Funeral Home: 21. Signature of Puperal Service License 2222 Wisconsin Ave., N.W. Washington, DC 20007 P 11 Enter the Isease, or com/lic hon that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only only cause on each line. Onset and Death Immediate ause (Final disease or condition resulting in death) **Physician** End Stage Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Atrial Fibrillation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) the death certificate be executed burial-transit Exami and Due to (or as a consequence of): physician s the burial Box 68760, Physician/Medical as attending IF FEMALE: nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ৹ in the past 12 months? 1 ☐ Yes 2 **X** No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. detached the 9 Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown r this certificate has been sirral director, page 2 should I Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 2 🔀 No 1□ Yes 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be Assisted Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Living Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred al or Attending P Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director: completely filled in by the f 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier H0064410 August 8, 2008 30. Name address of person who come eted cause of death (Item 23a) (Type, Print) Joanna Delaney, DO 10400 Connecticut Ave. Suite 606 Kensington, MD 20895 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 12 Good ! Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 9, Jacqueline Lopes August 2008 8:45 p Angele /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1821 Sherwood Road Silver Spring
If Under 24 Hrs. Montgomery If Under 1 Year 8. Date of Birth (Month, Day, Year)
March 23, Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 250 220-80-9652 84 1924 Director France Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code or Items 23a or 1821 Sherwood Road 20902 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Inportant: If item 27 is marked other than "natural", or Iter any injury or other traumatic event, the Medical Examinations. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: White þ 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be James McAleese 0 Angele Bertrand 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1821 Sherwood Road, Silver Spring, MD 20902 Frank Joseph Lopes/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug. 13, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery 2008 Silver Spring, Maryland 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licenses Francis J. Collins Funeral 500 University Blvd, W., S.

23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 500 University Blvd, . W., Silver Spring, MD 20902 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** a End-Stage Renal Discaso 5 years /Medical Due to (or as a consequence of): **Examiner** Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 30 years Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy Month Year in the past 12 months? Day 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Atherosclerotic Cardiovascular Disease, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has Cessation of Dialysis page 2 autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification; To this 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation 1x Natural death. 1 ☐ Yes 2 ☐ No after death Director: / 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide n 24 hours af ie Funeral Di bletely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) within 2 To the F and mariner stated. 29d. Date signed (Month, Day, Year) 0 29b. Signature and 29c. License number D47188 m August 11, 2008 30. n who completed cause of death (Item 23a) (Type, Print) ame and address o Jeffrey A. Perlmutter, MD 6240 Montrose Road, Rockville, MD 20852 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 12 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			State of Maryland / [artment of Health and M		_	27594
		•	For State Registrar	Cer	rtificate of Death	R	eg. No. 2 U U O	2/394
т	Physicia	n	1. Decedent's Name (First, Middle, Last)			Date of Dea Month	th Day Year	3. Time of Death
Film	/Medic		Edna Lee Lawrence			08/06	-	7:15 p ^M
1	Examin	er	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death	
	-	A	Crescent Cities Center 5. Social Security Number 6. Sex 7. Age (In yrs. last bir	rthday)	Riverdale If Under 1 Year If Under 24 Hrs.	8. Date of Birth	Prince Ge	orge's
и	Funeral Director		450.055	Yrs.	Months Days Hours Min.	(Month, Day 10/22/	, Year) Col.	place (State or Foreign intry) Missouri
	An transfer		Usual Residence of Decedent			10,22,		
	show at at	_	10a. State 10b. County 10c. City, Town	n or Lo	cation			10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f s	cto	MD Prince George's Hyatts	vil			024	
	with th	Dir	10e. Street and Number		10f. Zip Code		Og. Citizen of What Cou	•
	eath is 23	Funeral Director	6018 43rd Avenue 11. Marital Status 12. Was Decedent Ever in U.S.	13.	Was Decedent of Hispanic Origin? (Sp		United Stat	
	r Item	Fun	Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, White	, etc.
036	ral", o	by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No Specify:		Specify: W	hite
21215-0036	within 72 hours after death with the Maryland tene. Itan "natural", or Items 23a or 28a-f show h. Me Ical Examiner must be notified at h.	Completed by	15. Decedent's Education (Specify only highest grade completed)	. Deced	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ring	16b. Kind of Business/I	ndustry
121	vithin ne. han "	d m	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired) etary		USDA	
2	filed v Hygie ther t		12 So	ECT		e (First, Middle,	Maiden Surname)	
ano	d be ental	To Be	Leo Anthony Campisi		Eloise I	rances	Darling	
Maryland	2 should be filed within n and Mental Hygiene. Is marked other than "raumatic event, the Me	ř		o. Mailir	ng Address (Street and Number or Rui			ip Code)
	tra tra		Pamela Brown / friend 60	018	43rd Avenue, Hyat	tsville	, MD 20781	
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other once.	-	20a. Method of Disposition 1 □ Burial 2 ☑Cremation 3 □ Removal from State	of Dispo ery, crea	osition (Name of matory or other place)	Date	20c. Location - City or	Γown, State
Ë	Pag ment ant: I		4 □ Donation 5 □ Other (Specify) Metrop			11/08	Alexandria	
3all	permit Depart Import any In		21. Signature of Funeral Service Licensee		2. Name and Address of Facility	D. 4		more Avenue
	TD = 60		222 Deta Enter the diseases of multipations that sourced the death. Do		asch's Funeral Hon			Approximate
	-		23a 2411. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final			or respiratory and		Interval Between Onset and Death
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death) Pulmonary hy		tension			
	Examiner			,				
	7 ==	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c.	of):				
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60,	be eg cian cian	al E	resulting in death) Last Due to (or as a consequence	OI):				
687		dica	d					
Box (certif nding use as	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome pf pregnancy		-		23d. Date of deli	very
	death e atte d for	icia	in the past 12 months? 1 Ves 2 Fela death		□Ectopic pregnancy □ Other <i>(specify)</i>		Month	Day Year
P.0	at the by the tache	hys	9 ☐ Unknown					
	requires that the death certificate een signed by the attending phys hould be detached for use as the	by F	Part II. Other significant conditions contributing to death but not resulting i	in the u	inderlying cause given in Part I.		obacco use contribute to ′es 2 □ No 3 □ Pr	
Records,	w requir been si should	Completed	Coronary artery disease			'''		
3ec	aw Is b	nple				24a. Was autop		topsy findings available completion of cause of
alF	The Ticate his					1□ Yes	2⊠No 1 ☐ Yes	2 No
Vital	Physician: this certific ral director,) Be	25. Was case referred to medical examiner? 1 ☐ Yes 2☑ No Hospital: 1 ☐ Inpatient 2 ☐ EP/O	utnatie	26. Place of Dea		ne) lence 6 □Other (Spe	nife)
O	ding Physician: The In. After this certificate hatfuneral director, page	To :L	27. Manner of Death 28a. Date of Injury 28b.	Time o			now injury occurred	niy)
ion	Attending r death. ector: After by the funer	atio	2 Accident investigation	Injury	M 1 ☐ Yes 2 ☐ No			
Division	or Atter fiter dea Directo in by th	Certification:	3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 4 ☐ Could not be determined 28e. Place of injury - At home, fi building, etc. (Specify)	arm, st	reet, factory, office	28f. Location (5 City or Tox	Street and Number or Ru vn, State)	ıral Route Number,
D	oltal o urs aft eral D	Cer						
	Hosp 24 hol Fune Fune	Medical	29a. Certifier (Check only one) Check only one) Check only and manner stated.					
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Mec	29b. Signature and the of certifier		29c. License number		29d. Date signed (Mont	h, Day, Year)
	FSFO		> XIIMMON N.D		D64208		8/8/200	8
0	(12)		30. Name and address of person who completed cause of death (Item 23a)	(Туре			3707200	
1	0		Saadia Husain, 4409 East-West High			20737		
di.	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 3 2008 32. Registrar's Signature	A.	•			

DHMH 17 Rev 1/2001

VOID

CERTIFICATE

2008 - 27595

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CERTIFICATE #

2008 - 28395

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 20 Day 2008 2:30P August William Lease John 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) New WITIUS. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Aug. 6, Carroll 2639 Old New Windsor Pike 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) ^{Year)} 18 Maryland 1 X M 2 □ F 212-32-4270 90 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 ☐No New Windsor <u>Maryland</u> Carroll 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 2639 Old New Windsor Pike 21776 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑Yes 2 □ No If Yes, Give Year or Dates: 1 941 – 43 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1∐Yes 2⊠No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) dairy farmer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Rachael Ruth Chaney Samuel Lease 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) New 21776 19a. Informant's Name/Relationship (Type. Print) 2639 Old New Windsor Pike, P.O. Box 458Windsor, MD Dorothy E. Lease/ wife 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Evergreen Mem. Gardens 8/23/2008 Finksburg, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hartzler Funeral Home 21. Sign / e of Funeral Service Licen attaine New Windsor, MD_21776 310 Church St. 23a. Part1. Enter the disease, or complications that eaused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 48ars Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):

Examine the Hospital or Attending Physiclan: The law requires that the death certificate be executed sician and burial-trans Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical Completed by Be this caldire Certification: To : After this funeral o after death Director: d in by the Within 24 hours area
To the Funeral Dir

Physician

Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, If a Marical Examination and be notified at once.

Physician /Medical

Examiner

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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	d					
F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 4 ☐ Pregnant at time of death 9 ☐ Unknown			23	3d. Date of delivery Month Day	Year
Part II. Other significant conditions	contributing to death but not resulting	in the underlying cause of	iven in Part I.	23e. Did tobacco use	e contribute to the cause	
				I les 22	140 3 Trobably	
Dementia		·		24a. Was an autopsy performed? 1 □ Yes 2 ☑ No	24b. Were autopsy findi prior to completion death? 1 □ Yes 2 □ No	of cause of
25. Was case referred to medical			OC Disco of Doot	h (Check only one)	15100 2510	
examiner?	Hospital: 1 Inpatient 2 ER/0	Other (Specify)				
7. Manner of Death 1	(Month, Day, Year)	. Time of lnjury M 1	jury at ork? □Yes 2 □No	28d. Describe how injury	occurred	
3 ☐ Suicide 6 ☐ Could not determine		farm, street, factory, offic		28f. Location (Street and City or Town, State)	Number or Rural Route	Number,
29a. Certifier 1 Certifying I (Check only one) 2 Medical Ex	Physician: To the best of my knowled aminer: On the basis of examination and manner stated.	ge, death occurred at the and/or investigation, in m	time, date and place y opinion, death occur	, and due to the cause(s) arred at the time, date and p	and manner as stated. place, and due to the car	use(s)

29c. License number

00051924

29d. Date signed (Month, Day, Year)

August 22, 2008

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 2 7

npleted cause of death (Item 23a) (Type, Print) 2973 Manchester Ru Manchester MD Jr.MA 1. Henderson

32/Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year AUG 5 8:16PM M WALTER MOSLEY 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) ANNE ARUNDEL ANNAPOLIS CENTER ANNE ARUNDEL MEDICAL If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Davs | Hours | Min. | (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Months Days Hours 1**X** M 2 □ F 243 50 1183 70 SEPT 18 1937 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits WASHINGTON 1 Yes 2 No D.C. 10g. Citizen of What Country? 10e. Street and Number 20020 USA 30th STREET, S.E. 1301 12. Was Decedent **fryg ng** S. Armed Forces? thru 1 ⊠ Yes 2 □ No thru If Yes, Give Year or Dates: 1957 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2X Married 1 ☐ Yes 2 🔀 No Specify SpecifyBLACK 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GOVERNMENT CUSTODIAN 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SUSIE SHIELDS LESTER MOSLEY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) REGINA MOSLEY/WIFE 1301 30th ST., S.E. WASH. D.C. 20020 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition N☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/13/08 LINCOLN MEM CEM SUITLAND, MD 4 ☐ Donation 5 ☐ Other (Specify) 20010 21. Signature of Funeral Service Licensee 22. Name and Address of Facility WATSON F. H. 3435 14th ST., N.W.WASH DC. 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) OSEVCO Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy Month 4□Pregnant at time of death 5 ☐ Other (specify) 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Examiner

Physician/Medical

Completed

Be

Certification: To

Physician

/Medical

Examiner

10a. State

Funeral

Director

r 28a-f show notified at

r than "natural", or items 23a or the Medical Examiner must be a

Director

Funeral

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Completed

Be

death with the Maryland

filed within 72 hours after Hygiene.

permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other 1 any Injury or other traumatic event, <u>th</u>

Baltimore, Maryland 21215-0036

attending physician the signed by the a this funeral After 1

death certificate be executed

P.O. Box 68760

Division or Vital Records,

Hospital or Attending Physician:

24 hours after death Funeral Director:

within 24

filled in by

completely

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

24a. Was an performe 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

27. Manner of Death Natural 5 Pending investigation 2 Accident 3 Suicide

6 Could not be determined 4 Homicide

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work?

1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

29b. Signature and title of certifier

MD 30. Name and alidress of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

29d. Date signed (Month, Day, Year) 6

28f. Location (Street and Number or Rural Route Number, City or Town, State)

31. Date filed (Month, Day, Year)

AUG 1 3 2008

32. Registrar's Signature

State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month OOPM Toshiko Moriyama HU9 457 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Prince George's Doctors Community Hospital Lanham If Under 1 Year Months Days Hours Min. 8. Date of Birth (Month, Day, Year)
Sept 17, 19 Social Security Number Age (In yrs. last birthday Birthplace (State or Foreign Country) 1 □ M 2X F 89 1918 Los Angeles, CA 555-28-1787 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10h County 1X Yes 2 No Maryland Prince George's Mitchellville 10g. Citizen of What Country? 10e. Street and Number 10f Zin Code USA 20721 10450 Lottsford Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐Yes 2X No Specify Asian Specify: 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home 4+ Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Shizuko Kako Ito Tokuya Kako 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4 Tappan Road, Wellesley, MA Halley I. Moriyama - Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 8/13/08 Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service L 22. Name and Address of Facility 4739 Baltimore Ave. Gasch's Funeral Home, P.A. Hyattsville, MD 20781 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) ECTAL Due to (or as a consequence of): 1001 Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last a consequence of PO Due to (or as a consequence of): to coc 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ ☐ Inknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 21 No 1 Yes 25. Was case referr to medical examiner?

Physician /Medical Examiner

Physician

/Medical

Examiner

10a State

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examirer must be notified at

Baltimore, Maryland 21215-0036

1 and 2 should be filed within

and Mental Hygie is marked other

permit, Pages 1 and 2 s
Department of Health ar
Important: If item 27 is i
any injury or other trau.

Funeral Director

Completed by

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law requires that the death certificate be executed sician and burial-trans attending physician for use as the buria ed by the detached signed l has page 2 Hospital or Attending Physician: The

Box 68760,

P.0.

Records,

Division of Vital

Examiner Physician/Medical ģ Completed certificate Be Certification: To this After

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

1∐ Yes 2⊠ No

29a. Certifier

(Check only one)

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day, Year) 1 Natural 5 Pending investigation 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

28c. Injury at Work?

2 ER/Outpatient 3 DOA

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29b. Signature and title of certifier

 $\mathcal{M}\mathcal{J}$

767 410

29d. Date signed (Month, Day, Year)

20706

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AZEEZ 31. Date filed (Month, Day, Year)

AUG 1 4 2008



1 Depatient

and manner stated.

after death.

I Director: Af in by the fur

within 24 hours a To the Funeral D

filled in by

Medical

State

Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Date of Death
 Month 1. Decedent's Name (First, Middle, Last) Physician Ам 2008 9:41 08 Ruth D. Maschauer Aug. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's Adelphi Hillhaven Nursing Home 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 1 □ M 2 🗓 F 1915 93 June 24, 577-10-8745 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int; If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County at 1 ☐ Yes 2 No 28a-f sh notified Director Maryland | Anne Arundel Annapolis 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number must be n USA 21401 637 Wayward Drive Funeral 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Black, White, etc. "natural", or Item edical Examiner 1 K Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☒ No White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16b Kind of Business/Industry r than "natur the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Public Health Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Barbara Anna Scheuch Charles Phillip Maschauer ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 637 Wayward Drive, Annapolis, MD 21401 George H. Green / Nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1K Burial 2 □ Cremation 3 □ Removal from State permit. Page: Department o Important: If injury or 08/13/2008 | Suitland, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 21. Signatur c eral Service Licensee 22. Name and Address of Facility 4739 Baltimore Ave. Ju S Gasch's Funeral Home, P.A. Hyattsville, MD 20781 12 a. art1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition 5 Mm **Physician** disease or condition resulting in death) another 14784 /Medical Due to (or as a consequence Examiner Failure c Cardhomegaly 3 mallet gentra Candhac Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Hyportenyvo Candrovarda dunale Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) wound Leg = Non healing where Lays Division or Vital Records, P.O. Box 68760, the attending physician Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 🗷 No 4☐Pregnant at time of death 5 Other (specify) 9□Unknown 9 ☐ Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 | Yes 2 | No 3 | Probably 4 Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2X No certificate has 1□ Yes Chronic 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director. Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes Certification: To this funeral 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Deal 28c. Injury at Work? After t (Month, Day Year) Injury or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident hours after death uneral Director: filled in by the 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide hin 24 hours at the Funeral C Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a, Certifier completely the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Terrica # 18102 Hyalistille Md. 20782 3311 31. Date filed (Month, Day, Year) State AUG 1 4 2008

Registrar
DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8, 2008 Year **Physician** 3:45 PM August Harold C. Markward, Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hosptial Bethedsa 8. Date of Birth (Month, Day, May 31, If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday **Funeral** Days Hours Min 1933 Washington, DC 579-42-6497 75 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show d other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1X Yes 2 □ No Director MD Silver Spring Montgomery 10a. Citizen of What Country? 10e. Street and Number 1312 Wembrough Court 20905 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1XYes 2□No 1952− Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc 72 hours after 1 Never Married 2 Married Specify: White Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. þ 3 ☐ Widowed 4 ☐ Divorced 1956 Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) previnit. Pages 1 and 2 should be filed within 72. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "namenty injury or other traumatine." (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) IBM Corporation 12 Pressman 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Harold C. Markward, Sr. Elizabeth C. Maxwell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1312 Wembrough Court Silver Spring, MD 20905 Gloria P. Markward (wife) Baltimore, 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 【XI Cremation 3 ☐ Removal from State Fort Lincoln Crematory 8.14.2008 Brentwood, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fort Lincoln Funeral Home 21. Signature of Funeral Service licensee Kalut, Brentwood, MD 20722 3401 Bladensburg Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Cardiac arrythrmia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 1 week Acute renal Failure Sequentially list conditions, Due to (or as a consequence of) Examiner It say leading to introdic cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last 2 weeks Staph Bacteremia attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 Other (specify) signed by the a d be detached for I ☐Yes 2 ☐ No 9 ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown After this certificate has been s funeral director, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 ☐Yes 2X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \)Other (Specify) Hospital: 1 ☐ Yes 2 ♣ No Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 ☐ Pending investigation 1 🖺 Natural 1 □Yes 2 □ No To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Acciden 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1XI Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10215 Fernwood Rd. Suite 405 Bethesda, MD 20817 John Merendino, MD 31. Date filed (Month, Day, Year)

ALIG 1 4 2008 32. Registrar's Signature State AUG 1 4

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Registrar

MARKWARD, HAROLD

For State of Mar State Registrar	yland / Department of Health and M Certificate of Death	lental Hygiene 008	27601
ecedent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
George Aloysius Mattingly	Sr	Month Day Year	11:55 Рм

Physician /Medical Examiner

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Funeral Director

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death with the Maryland ir than "natural", or items 23a or 28a-f shov the Modicel Examiner must be notified at permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural, or iten any injury or other traumatic event, the Mudical Exaction

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

The law requires that the death certificate be executed physician at s the burial-t S the attending esn ō signed by 99 peed has page this certificate the Hospital or Attending Physician: After the Director:

Division of Vital Records, P.O. Box 68760,

4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Calvert Memorial Hospital Prince Frederick Calvert If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Months Days Hours Min. July 15, 19 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 10XM 2□ F 82 Yrs 220-16-4250 1926 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 1⊠Yes 2 No Director Maryland St. Mary's Leonardtown 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code USA 22765 Lawrence Avenue 20650 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 ☐ No If Yes, Give 1 Never Married 2 Marned 1 ☐ Yes 2 No Specify: Specify: White þ If Yes, Give Year or Dates: 3 X Widowed 4 ☐ Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Public Work Supervisor U.S. Government 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Zachariah Milton Mattingly, Jr. Catherine Palace Poe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 26 Cross Point Drive Carla Jean Murphy / Daughter Owings, MD 20736 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State August 25 Charles Memorial Gardens Leonardtown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 2008 21. Signature of Funeral Service Licensele 22. Name and Address of Facility Mattinuley-Gardiner Funeral Home, P P.O. Box 270 Leonardtown, MD 20650 ichae bardine Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cruse on each line. Immediate Cause (Final disease or condition resulting in death) Pulmonary Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Respiratory 3 ☐ Probably 4 ☑ Unknown 1 Tyes 2 □ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No HYDOXICO 24a. Was an autopsy performed? Atheroscienotic Cordio voscular diseate 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 ☐ Yes 2 ☑ No 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Matural 5 Pending 1 Yes 2 No investigation 2 Accident npletely filled in by the 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50653 8-19-2008 Suraro Gran.c. Surona 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851 200 € Donal Dodde. 31. Date filed (Month, Day, Year) State

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within 24 hours a To the Funeral D

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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician August 18, 2008 9:03 p Moody Bonita Mae /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Mechanicsville 26889 Baptist Church Road If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 1 □ M 2 🔼 F West Virginia July 3, 218-26-9875 85 1923 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lipinry or other traumatic event, I're Meritcht Examiner must be rediffied at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 X No Director Mechanicsville Maryland St. Mary's 10g. Citizen of What Country? 10e. Street and Number USA 26889 Baptist Church Road 20659 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No Specify Specify þ White 3 ₩ Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Turley Nelly Needham Ezra ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 26889 Baptist Church Rd., Mechanicsville, MD 20659 Wade Moody/Son Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State National Memorial Park 8/23/2008 Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, P.A.
P.O. Box 128, Charlotte Hall, MD 20622 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** C Seque tially is condition if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) signed by the a I ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🐼 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has e 2 s 2 □ No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2¶ No 1 🔲 Inpatient 2 ER/Outpatient 3 DOA မ After thi funeral of 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: d in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours aft

To the Funeral Di

completely filled in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier **Medical** 2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manager stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) nree Notch Rd. Hollywood 31. Date filed (Month, Day, Year)
AUG 2 1 2008 State Registrar

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 2008 0010 THOMAS WELDON MONTEITH, JR. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner TALBOT EASTON MEMORIAL HOSPITAL | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | JAN 7, 1932 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday 5. Social Security Number 6. Sex **Funeral** Country) 1 XM 2 □ F PA 76 Director 160-26-6893 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No TRAPPE Director TALBOT MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 4440 BAILDON ROAD 21673 USA Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼No If Yes, Give 11. Marital Status Black, White, etc after 1 ☐ Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 "natural", or 1 ☐ Yes 2 🙀 No þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 72 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) LIFE INSURANCE CO 12 ATTORNEY permit. Pages 1 and 2 should be filed 1 Department of Health and Mental Hygis Important: If item 27 is marked other 1 any Injury or other traumatic event, <u>tr</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be THOMAS WELDON MONTEITH ELIZABETH MOYER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) JANE HUNTER MONTEITH/WIFE 4440 BAILDON ROAD, TRAPPE, MD 21673 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 □ Cremation 3 □ Removal from State 8/16/2008 BRYN MAWR, PA 4 ☐ Donation 5 ☐ Other (Specify) CHURCH OF THE REDEEMER Signature of Funeral Service Licenses FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 CHN MERCERON Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician **PNEUMONIA** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner DEHYDRATION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed BACTEREMIA Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. If yes, outcome pf pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 🏋 ☐ No 3 ☐ Probably 4 ☐ Unknown SMALL BOWEL OBSTRUCTION Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s 1 Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: . 2**X** No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 TYes Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 28c. Injury at Work? 27. Manner of Death (Month, Day Year) Injury 1X Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: / 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours after Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier TLS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 DENNIS M. DESHIELDS M.D. 219 S. WASHINGTON ST., EASTON, MD 21601 2. Registrar's Signature State Registrar

			_ State	tate of Maryland		rtment of H tificate of I			giene Reg. No.2008	27604	
			Registrar 1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath	3. Time of Death	
	Physicia		REGINALD B. MEDLO	CK				Month Aug	Day Year 8 2008	7:55 PM	
Šà	/Medic Examin	100	4a. Facility Name (If not institution, give stree				Location of Death		4c. County of Dea	ath	
F 171	75. 500		Genesis HealthCa				ston		Talb		
	Funeral Director		5. Social Security Number 6. Sex 1 X M	2□ F 7. Age (In yrs. In 71	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Day SEPT.	v. Year)	rthplace (State or Foreign Country) RTH CAROLINA	
	p ,		Usual Residence of Decedent 10a. State 10b. County	10c City	, Town or Loc	cation				10d. Inside City Limits	
	n the Maryland r 28a-f show i notified at	ក								Yes 2□No	
	the M 28a-f otific	Director	MD BALTIN 10e. Street and Number	IURE	DA	10f. Zip Code			10g. Citizen of What C	Country?	
	with ta or		2017 KELBOURNE RD.			21237	7		USA		
	ms 23	Funeral	11 Marital Status 12.	Was Decedent Ever in U.	S. 13. V	Vas Decedent of H	ispanic Origin? (Sp	ecify Yes or No	14. Race - Am		
٥	172 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at		1 Never Married 2 Married	Armed Forces? 1 XYes 2 No If Yes, Give		Yes, specify Cuba	an, Mexican, Puèrfo Specify:	ricali, etc.)	Black, White, etc.		
5-0036	ural",	d by	3 Widowed 4 Divorced	Year or Dates:						WHITE	
<u>7</u>	"natu	ete	15. Decedent's Educati (Specify only highest grade co	on impleted)	16a. Deced (Give	ent's Usual Occup kind of work done of OO NOT use retired	ation during most of work d)	ing	16b. Kind of Busines	s/mustry	
12	be filed within 72 ho tal Hygiene. d other than "natui event, the Medical	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 4		URSE	•/		HEALTH	CARE	
N O	other ent, tl	Be Co	17. Father's Name (First, Middle, Last)	•	<u> </u>		18. Mother's Nam	e (First, Middle,	Maiden Surname)		
Maryland	should be nd Mental marked o	To B	ALBERT A. MEDLOCK				BLANCH	E. WEAV	ER		
ary	ĕ E E		19a. Informant's Name/Relationship (Type.	Print)	1				er, City or Town, State		
	カモトキ		DENNIS O. MEDLOCK/BI						MICHAELS,		
altimore,	of F of F f Ite		20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Rem	Constitution Charles C	emetery, cren	sition (Name of natory or other place	ce) ¦	Date	20c. Location - City of		
Ě	Pages ment of lant; If Its	Ι.,	4 ☐ Donation 5 ☐ Other (Specify)	CHE			-	/11/200	8 STEVENSV	ILLE, MD	
Ball	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	ERLERON	FE	Name and Addre LLOWS, HI O S. HARI	ELFENBEIN	& NEWN	AM FUNERAL N, MD 2160	HOME, PA	
			23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of							Approximate Interval Between	
e :	Physician		Immediate Cause (Final disease or condition	HEPAT	70 4	NOET	HACU!	HTAD	×	Onset and Death	
	/Medical		resulting in death)	Due to (or as a conseq	uence of):		HACUI HOSIS		-		
C.	Examiner	L	Sequentially list conditions b	LIVEC	< (IRRH	2120			MONTHS	
	pe tis	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c	Due to (or as a consequent	uence or):						
	xecut and I-tran	Examiner	that initiated events c resulting in death) Last	Due to (or as a conseq	uence of):						
8760	icate be executed physician and s the burial-transit										
89	ificate g physis the	edical	u								
Box	leath certific attending p	n/M	IF FEMALE: 23c. Was decedent pregnant	If yes, outcome pf pregna 1 ☐ Live birth 2 ☐ Feta		Ectopic pregnanc	v		23d. Date of d		
m .	deatl le atte ed for	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d		Other (specify)	y 		Month	Day Year	
P. O.	at the by th	ly S	9 🗆 Unknown				to Pour I	l oon Did	labana yan gantsibuta	to the cause of death?	
S,	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	þ	Part II. Other significant conditions contri	buting to death but not res	uiting in the u	nderlying cause giv	en in Part I.			Probably 4 Munknown	
Records,	w require been sign	Completed						24a, Was	an 24h Were	autopsy findings available	
Re	has l	lg m					-	auto perfe	psy prior to prmed? death	to completion of cause of	
	n: Th ficate or, pag		25. Was case referred to medical				26. Place of Dea	1 Yes		′es 2□No	
Vita	sicia s certi irecto	o Be	evaminer?	pital: 1 □ Inpatient 2 □	ER/Outpatier	nt 3□ DOA Oth	205: 3		idence 6 □Other (S	pecify)	
Ö	Attending Physician: r death. ector: After this certifics by the funeral director, I	n: To	27. Manger of Death	28a. Date of Injury (Month, Day Year)	28b. Time o				how injury occurred		
0	ath. rr: Aft	atio	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	(World), Day Your)	lingury		Yes 2 □ No				
Division or	r Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	 Place of injury - At he building, etc. (Specifical) 	ome, farm, str fy)	reet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,	
	ital o					b d -4 4b - 4'	See data and also		(a) and	an atated	
	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Medical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examine	ian: To the best of my knot: On the basis of examination and manner stated.	owiedge, deat ation and/or in	n occurred at the ti ivestigation, in my	opinion, death occu	r, and due to the irred at the time	, date and place, and o	due to the cause(s)	
	Fo the vithin Fo the comple	Me	29b. Signature and title of certifier	200		29c. Licens	se number	-	29d. Date signed (Mo	onth, Day, Year)	
	125		1/4	from In	W	1	72543	9	8/11/0	38	
,	5+VA		30. Name and address of person who com	11008 0	10 " 1	Print)	10 10.	1 1	-Anni I r	mA 21001	
			31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	UICHMAI	NZ KIN		175/W,1	110 21001	
	St Regist	ate trar	AUG 1 1 200		15 A	mel					

State of Maryland / Department of Health and Mental Hygiene 🛭 🛭 🖯 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) AUGUST **Physician** 3:15 2008 June Elaine MURPHY /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Western Maryland Hospital Center

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Washington Hagerstown If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□M 2፟XF Months 73 Sept 28 1934 Director 217-30-5812 Maryland Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a, State 28a-f show traumatic event, the Medical Exacultar must be notified at 1 Yes 2 □ No Director Hagerstown Maryland Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ō or items 23a 21740 <u>USA</u> 852 Snyder Avenue Completed by Funeral 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 XX No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) State Government Health Records Practioner 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be should be nd Mental marked o Wesley Resh Frances Rhoades ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 19a. Informant's Name/Relationship (Type, Print) f Health 97 Manassas Drive, Falling Waters, W. Va. 25419
ce of Disposition (Name of Date 20c. Location - City or Town, State Thomas P. Murphy - Son other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition ŏ Department of Important; If it any injury or o once. Burial 2 Cremation 3 Removal from State Broadfording Memorial 8/18/08 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death CONGES Immediate Cause (Final TIVE **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine 3-4 MONTHS attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IE FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? ste has been signed I page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ ELECTROLY ABNIRMALIT 3 Probably 4 Nhknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2□ No 2 No 1 Tyes To the Hospital or Attending Physicien: within 24 hours after death.

To the Funerel Director; After this certifica completely filled in by the funeral director; for the funeral directors and directors are directors. 26. Place of Death (Check only one) 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number 0064 08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1500 Pennsylvania Avenue 05H-L Muhammed Abdullah, MD Hagerstown, MD 21742 31. Date filed (Month, Day, Year) gistrar's Signature State AUG 1 8 2008 Registrar

08-06006 Christian Menk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 27606

		For State			Certific	ate of	Death					Reg. No.				_
Physician/	1.	Decedent's Name (First, Middl hristian Arthu	e,Last) ur Menl	ζ							Month	Day	Year		3. Time of Death 1149 hrs	
য় Examine	1					14	b. City, Town	or Loc	cation of		August 6		c. County of	Death		-
	4a	i. Facility Name (if not institutio University Hospital	n, give street	and number)			Baltimore									
Funeral	5.	Social Security Number	6. Sex	7. Age (In	yrs. last bi	rthday)	If Under 1	Year	If Under	_	8. Date of E	Birth (MM.	/DD/YYYY)	9. Birth Foreign	place (State or	\exists
Director		14-98-6676	1 X M 2	F	32	Yrs.	Months [Days	Hours	Min.	03/21	/197	76	Cou	ntry)Chile	
		sual Residence of Decedent													10d. Inside City Limit	+6
any		0a. State 10b. County			City, Tow		on							1	1 Yes 2 X N	- 1
Maryland 28a-f show any d at once.	5 M	laryland Anne	Arund	el le	Edgew	ater						10= Cit	izen of Wha	at Coun		4
the Maryland a or 28a-f sh tiffed at once	10	e. Street and Number					10f. Zip Coo									
th the M 23a or 2 notified		882 Annapolis				140.144-	2103 s Decedent o		nio Origi	n2 / Sne	cify Ves or I		ted St		an Indian, Black,	-
r death with or items 23 must be no		1. Marital Status Never Married 2 X M	iarried A	/as Decedent Ever rmed Forces? Yes 2		13. Was	es, specify Cu	iban, N	nexican,	Puerto F	Rican, etc.)	•	White,		,,	ļ
er dea			orced If Yes,		No	1	Yes 2 X	No s	specify:				Specify: (Chi1	.ean	
tural"	<u> </u>	15. Decedent's Education (Spe	or Dat	98'	ted) 16a	a. Deceden	t's Usual Occ	upation	Give k	ind of wo	ork done	16b.	Kind of Bus	iness/l	ndustry	
n "na al Exa	najaidillo 1	Elementary/Secondary (0-12)	Co	ollege (1-4 or 5+)			ost of working	gilite. D	ONOIL	ise reure	:0)				L	
5-0036 Jed within 7 Hygiene. I other than the Medica	틸	12			E	lectr	rician	140	1 4 - ()d-	- Noma	Circh Middle		onstru n Surname)		.on	
5-0 iled v Hygi d other	3 1	7. Father's Name (First, Middle Garry Menk	, Last)								Mulla:		ii Surrame,			ij
should be filed within 72 and Mental Hygiene 7 is marked other than matic event, the Medical TO Be Comple	ן מ	9a. Informant's Name/Relations	ship (Type, P	rint)		9b. Mailing	g Address (S						City or Towr	n, State	, Zip Code)	\dashv
a s L		my L. Menk/Wi		,								wate:	r, Mai	ry1a	ind 21037	
rre, MC s 1 and 2 sl of Health ar If item 27	2	0a. Method of Disposition				e of Dispos	sition (Name o	of ceme	etery,		Date	200	. Location -	City or	Town, State	ļ
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traum	1	Burial 2 X Cremation Donation 5 Other S		moval from State		•	ematory	Į.		08/	08/200	08 E	dgewat	ter,	Maryland	.]
Baltimo Department Important: injury or of	2	1. Sign e of Funeral Se	E Licensee												al Home	
E P E	Ť.	MA Sua				29	973 Sol	Lomo	ons .	Isla	nd Roa	ad,	Edgewa	ater	, MD 2103	
`hysician Medical	2	Part I. Enter the disease, of failure. List only one cause	e on each line	€.			ne mode of a	ying, si	uch as ca	argiac or	respiratory	arrest, s	HOOK, OF HO	ai t	Between Onset a	
Examiner		mmediate Cause (Final diseas or condition resulting in death)		act Gunshot		of Head								_		- 12
			b.	(or as a consequ	ierice or _j .											
	<u>ا</u> ۾	Sequentially list conditions, f any, leading to immediate		(or as a consequ	uence of):											
	티	Disease or injury that initiated	G	o (or as a consequ	uence of):					_						- 73
uted Id ansit		events resulting in death) Last _	d	<u> </u>												-
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AM	ENDED												
760, icate be physic the bur		F FEMALE: 3b. Was decedent pregnant in		c. If yes, outcome	of pregnar				Estania	o pronns	incv	1	23d. Date of Month		y Day Year	
68/ certific nding ise as 1	sician	past 12 months?	14	Live birth Pregnant at tir	ne of death		etal death other (Specify		Ectopi	c pregna	ПСУ	. 1	Morra			
O. Box 687 at the death certific d by the attending getached for use as the	ysic		nknown g	Unknown												
O. E		Part II. Other significant cond	litions cont	ributing to death b	out not resu	Iting in the	underlying ca	ause gi	ven in Pa	art I.					the cause of death?	
i, P.O.	d by														utopsy findings avail	
ords, F	흥										a	Vas an utopsy erformed		prior to death?	completion of cause	of
ecc in lav	Completed													✓ \)
Division of Vital Records, ta for Attending Physician: The law requirers after death. "In Director: After this certificate has been sided in by the funeral director, page 2 should be an or the funeral director, page 2 should be a sho	Bec	25. Was case referred to medic examiner?						10	of Death Other <u>'</u> ₄		only one)					
Vita	၉၂	1 ✓ Yes 2 No	Hospit	Impation	2 🗸 E			^	y at Wor		ng Home 5		idence 6 injury occur	Oth	er: 	
n of ling Pl After funera	Ë	27. Manner of Death 1 Natural 5 Pe	- 1	28a. Date of Injury (Month, Day, Yea Aug 5, 2008		8b. Time of 027 hrs		_	es 2 🗸	_	Subject	shot se	əlf			
Vision of Vor Attending Pher death. Director: After tin by the funeral	Ĭġ	5 Pe	estigation	28e. Place of Inju		e form str					28f. Locati	on (Stre	et and Numi	per or F	Rural Route Number,	City
Division Hospital or Attent 24 hours after death Funeral Director:	Certification:	de	ould not be	(Specify) Majo				JIIIOO DI	onang, a		or To	un State				
Ospital ospital hours a uneral I	ို	4 Homicide 29a. Certifier 1 Certifying		To the best of my				me, da	ite and p							
Division of Vital Records, P.O. Box 68. To the Hospital or Attending Physician: The law requires that the death certifi within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		(Check only one) 2 Medical E:	xaminer:On	the basis of exam manner stated.	ination and	or investig	ation, in my o	pinion,	death o	ccurred	at the time,	date and	place, and	due to	the cause(s)	_
To Too	ĕ⊦	29b. Signature and title of cert		<u> </u>			29c.	License	e numbe	r			_	,	lonth, Day, Year)	
		(X 12-2)	brle	(W)				O.C.I	M.E.				August 8,	2008		
	+	30. Name and address of pers				3a)		D		4D 04	204					
O1 LH)				Medical Exa			nn Street,	Baltin	nore, N	AD 212	201					
Sta Registi		31. Date filed (Month, Day, Yea	2 2008	32. Figistrar		× A	book									
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			_ FUI	State of Maryland	•		Mental Hygi	ene2008	27607
			State Registrar		Certificat	e of Death	Reg	g. No.	3. Time of Death
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Cary Lamar	- Minnief			Month 08	Day 09 Yea70	8 023C(AM)
	Examir	er	4a. Facility Name III not institution, give si	Medical C	enter A. City.	Town, or Location of Dea		4c. County of Death	randal
	Funeral Director		5. Social Security Number 6. Sex 100 - 31 - 3920 100	M 2□F	t birthday) If Under Months	Days Hours Min		Year) 9. Birth.	olace (State or Foreign ntry)
			Usual Residence of Decedent 10a. State 10b. County	10c City	Town or Location				10d. Inside City Limits
	e Maryla ta-f ehor	ctor	ma Ame A	and GI	enBurn	i.e			1 Tyes 20 No
	3a or 28	al Director	10e. Street and Number	e Cr	10f. Zip	1061	10	g. Citizen of What Cou	ntry?
36	hours after death with the Maryland tural', or Iteme 23a or 28a-f ehow al Exercitivet must be indiffed at	by Funerai	11. Marital Status 1 Xever Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 [X]No If Yes, Give Year or Dates:	13. Was Dece If Yes, spe 1 \(\superscript{\text{Yes}}\)	dent of Hispanic Origin? cify Cuban, Mexican, Puo 2 No Specify:	(Specify Yes or No- erto Rican, etc.)	14. Race - Ameri Black, White	
21215-0036	within 72 ene. than "nat	Completed b	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	life. DO NOT u	ork done during most of w		6b. Kind of Business/Ir	ndustry
Maryland 2	be filed stat Hygi od other event, I	To Be Co	17. Father's Name (First, Middle, Last) Cary Lamai	- minnie F.	ild Jo	18. Mother's N	ame (First, Middle, M	chele Sc	crivner
Mar	and 2 shoutd lealth and Mer m 27 Is marke har traumatic		19a. Informant's Name/Relationship (Type	e, Print)	19b. Mailing Address	(Street and Number or	21 12	City or Town, State, Zi	19 21061
Baltimore ,	of H of H or of		20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20b. Place amoval from State Carp	e of Disposition (National Property Communication of Disposition (National Property	me of phier place) 8/1	Date 2 8/2008	Oc. Location - City or T Severna Pa	
Baltii	permit. Pag Department Important: any Injury o		21. Signature of Suneral Service License		22. Name ar	nd Address of Facility Ety Funeral	Home P.A.	12 Ridgely	21401 Ave Ann,MD
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on Immediate Cause (Final	eations that caused the death.	. /				Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	Due to (or as a conseque	Necrot	12ing E	nterocoli	43	1 day
		Examiner	Equentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events	Due to (or as a conseque	nce of):				
,09/	ate be executed sysicien and he burial-transit	Ical	that initiated events resulting in death) Last	Due to (or as a conseque	nce of):				
.O. Box 68	The law requires that the death certificat ste has been signed by the attending phy page 2 should be detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. If yes, outcome of pregnanc 1 □ Live birth 2 □ Fetal d 4 □ Pregnant at time of dea 9 □ Unknown	eath 3 Ectopic p			23d. Date of deli Month	very Day Year
Q	luires that n signed b	٥	Part II. Other significant conditions con Extreme Low	ributing to death but not result Birth Weigh			23e. Did tob	acco use contribute to s 2 ☑No 3 ☐ Pro	the cause of death?
Vital Records,	The law requir sete has been sl page 2 should	Completed		<u> </u>	,		24a. Was an autopsy perform 1 Yes 2	prior to c death?	opsy findings available ompletion of cause of
Vita	Physicien: 1 this certificer ral director, p	Be	25. Was case referred to medical examiner?	ospital:	- W-		eath Check only one	` -	
o	Phys	n: To	27. Manner of Death	1 Vinpatient 2 El	R/Outpatient 3 De Bb. Time of Injury	OA Other: 4 Nursing 28c. Injury at Work?	Home 5 Resider	nce 6 Other (Spec w injury occurred	ify)
Division	deatl deatl ctor: / the	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At hom building, etc. (Specify)	М	1 ☐ Yes 2 ☐ No	28f. Location (Str City or Town	reet and Number or Ru	ral Route Number,
ā	urs afte								
	To the Hospital or At within 24 hours after of To the Funerel Direct completely filled in by	edical		ician: To the best of my knowler: On the basis of examinational and manner stated.					
	To the comp	×	29b. Signature and title of certifier	1.3	29	c. License number	29	ed. Date signed (Monti	
			30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type, Print)	D47158	A	ugust 7,	2008
	1(4)		Yann - Yaı 31. Date filed (Month, Day, Year)	n Lin 20	ool medi	il Perku	& Ame	polis . A	1/2 9/40/
1	Sta Regist		AUG 1 2 200	32. Jegistrar's Signatu	& Speed	,			

27608 3. Time of Death

			Pleas	e Type or Print i	in Black	Indelible Ink	. Ensure A	II Copies	Are Leg	ible.	
			For State Registrar	State of Mary		epartment of H Dertificate of			giene 2 (Reg. No.	08	27608
I	Physici /Medic		1. Decedent's Name (First, Middle,	Last) WER MESSICK				2. Date of De Month	Day_	Year 08	3. Time of Death O214 M
	Examin		4a. Facility Name (If not institution, FININSULA REGIO		ENTER		or Location of Death いない			y of Death	
	Funeral Director		5. Social Security Number		ı <i>yr</i> s. last birth Yı	day) If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th ly, Year) 1970	9. Birth	place (State or Foreign intry)
	Maryland -f show	tor	Usual Residence of Decedent 10a. State 10b. County	mico	c. City, Town o						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	s 1 and 2 should be filed within 72 hours after death with the Maryland f Heathh and Mental Hygiene. I feel them 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Modest Eventual penaltical at	al Direc	10e. Street and Number 10f. Zip Code 10g. Citizen of What USA								intry?
036		by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marrie 3 ☑ Widowed 4 ☐ Divorced	Armed Forces?	1 ☐ Yes 2 ☐ Mo Specify: Specify: Specify:						
Maryland 21215-0036	d within 72 ho giene. r than "natur tt. Woden	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)		ecedent's Usual Occup Give kind of work done ife. DO NOT use retire	during most of work	ing	16b. Kind of E		ndustry
land	should be filed within nd Mental Hygiene. marked other than "	To Be C	17. Father's Name (First, Middle, La				18. Mother's Nam			me)	
	and 2 shoulath and 1 stand 1 s		19a. Informant's Name/Relationship	p (Type. Print) [Personal 1		Mailing Address (Street					
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other trai		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe	ecity)		hisposition (Name of crematory or other place of the company of th		Date	20c Location	- City or To VEっか	own, State
Balt	permit. Departr Importa any inju		21. Signature of Funeral Service Li	censee ms LLC#		22. Name and Addre	ess of Facility Universal Hom	E PO BO	K CH BW	nower,	MD 61814
	Physician		23a. Part 1. Enter the disease, or conshock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	omplications that caused the nly one cause on each line.		t enter the mode of dyi	ng, such as cardiac	or respiratory a	rrest,	2	Approximate Interval Between Onset and Death
1	, /Medical Examiner	er	Sequentially list conditions,	b. Due to (or as a co	Renal	Failund	೬				
	executed n and al-transit	zaminer	cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c Due to (or as a co							

Examine been signed by the attending physician and should be detached for use as the burial-transit Physician/Medical þ Completed page 2 certificate has Be Certification: To

The law requires that the death certificate be executed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p

Division of Vital Records, P.O. Box 68760,

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 27. Manner of Death

IF FEMALE:

23b. Was decedent pregnant

9 Unknown

1 Yes 3 No

2 ☐ Accident

3 Suicide

29a. Certifier (Check only one)

30. Name and

4 ☐ Homicide

in the past 12 months?

State Registrar

Medical

VOH LOGE 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Hospital: Inpatient

28a. Date of Injury (Month, Day, Year)

23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death

9 Unknown

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably

24a. Was an autopsy performed? 1 □ Yes E 400

24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2日No

Year

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

D 63199. s of person who completed cause of death (Item 23a) (Type, Print)

SALISBURY, MD, 21804 DR

614 EASTERN istrar's Signature

5 Pending investigation

6 ☐ Could not be

determined

2 ER/Outpatient 3 DOA

28b. Time of

Injury

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year 14:00 **Physician** PHUNG AUGUST 2008 TRAN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Vietnam 579-06-4947 50 12/02/1957 Director Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a. State 10b. County show d other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 1 ☐ Yes 2 🛣 No Director Maryland Montgomery Germantown 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 20800 Scottsbury Drive 20876 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after one of Health and Mental Hygiene. The filem 27 is marked other than "natural", or iten 1 Tes 2 If Yes, Give Year or Dates: 2 🔼 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Jefferson Hotel Engineer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Quynh Thuy Phung Son Mau Lam 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 Item other tra Wei-Jun Shen - Spouse 20800 Scottsbury Drive, Germantown, Maryland 20876 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 S Cremation 3 Removal from State 08/13/2008 Ft. Lincoln Crematory Brentwood, Maryland 4 Donation 5 Other Specify 22. Name and Address of Facility 21. Signature of Fune Silvine Licensee Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, block, or leart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician Circhosis disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Heraballular Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed burial-transi Due to (or as a consequence of) Box 68760, physician Physician/Medical the as nding use a 23c. If ves. outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death ☐ Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) 2 No detached P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Id be de Completed by 2 No 3 Probably 4 Unknown certificate has been sig lirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes 26. Place of Death (Check only one) director, 25. Was case referred to medical Be Other: 4 Nursing Home Hospital: 1 Inpatient 1 Yes 2 No 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) မ After this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manger of Death Certification: 5 Pending investigation 1 Natural 1 Tes 2 No М

Division of Vital Records, or Attending Physician: after death Director: filled in by within 24 hours af

To the Funeral DI

completely filled in Hospital

2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier Medical (check only

KARTHIK

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

RES-000

29b. Signature and title of certif

29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

600 North Wolfe St, Baltimore, MD, 21287

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State Registrar

SURESH MD 38. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

To the

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** AUGUST 2008 10 MARIA PALMATECK /Medical 4b. City, Town, or Location of Death 4c. County of Death ty Name (If not institution, give street and nur **Examiner** The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Date of Birth (Month, Day, Year **Funeral** Hours 1 M 2 XF North Carolina Aug. 8, 1927 81 579-26-9418 Director Usual Residence of Decedent 10d. Inside City Limits Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. 10c. City, Town or Location 10a, State 10h Count shov or 28a-f shov notified at 1 Yes 21 No Director Kensington Maryland Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ö Examiner must be IISA 20895 23a 10423 Fawcett Street, #202 Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? , or items 11. Marital Status 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: White δ 3 Widowed 41 Divorced 'natural", Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Own Business Antique Dealer 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland Be is marked Frances Grabil George Allen Cox 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 505 Beaumont Road, Silver Spring, MD 20904 Frances P. Goldfinger/Daughter Department of Health a Important: If item 27 is any injury or other trace Baltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 14, Aug. 2008 National Memorial Park Falls Church, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22 Name and Address of Eacility Francis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 2090 Hales Techard Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) HOUTE /Medical Due to (or as a consequence Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine The law requires that the death certificate be executed ATHEMOSCUENOSIS nding physician and use as the burial-tran resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical , ORDINARY attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown P.0. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 Division of Vital Records, 2 No 3 Probably 4 Unknown HORFIC STEMSIS Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an STEMOSIS MITMAL autopsy performed? certificate has 1 🗌 Yes 2 No Yes 2 No promouply HYPERTENSION Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 patient 2 ER/Outpatient 3 DOA After this 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 1 Natural 5 Pending investigation М death. 2 Accident s after death 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide filled in by 4 Homicide 6 24 hours the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 hou

To the Funel

completely fi Medical (check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier ၉ Rt.5.000 most mo, tress of person who completed cause of death (Item 23a) (Type, Print) 30. Name and a 600 North Wolfe St, Baltimore, MD, 21287 ROMAN mo MA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 12 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 0 **Physician** UTRO INICK 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Age (In vrs. last birthday **Funeral** Days Hours Min. 1 M 2 F 11-5-1927 Maryland Director 80 209-20-6224 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show notifled at Crofton MD Anne Arundel 1 ☐ Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code a or 21114 USA 1636 Eton Way "natural", or Items 23a edical Examiner must b Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 21 No 1 🗌 Yes Specify: Specify: White Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Medical nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Operating Room Nurse Manager Hospitals s 1 and 2 should be filed v f Health and Mental Hygie Item 27 Is marked other 1 other traumatic event, tb 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Boswell Ruth Stevenson ဂ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) J. Byron Patrick/Husband 1636 Eton Way, Crofton, Maryland 21114 permit. Pages 1 and Department of Health Important: if Item 27 any Injury or other tr. Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 ☐Removal from State Maryland Veterans Cem. 8/14/2008 Crownsville, MD 4 ☐ Donation 5 ☐ Qther (Specify) 21. Signature of Furral ervice Licensee 22. Name and Address of Facility Beall Funeral Home 6512 NW Crain Highway, Bowie, Maryland 20715 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complic shock, or heart failure. List only on tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician len /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examiner that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknow signed by i Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has page 2 autopsy 1∏ Yes Division or Vital or Attending Physiclan: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ After thi funeral of 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation To the Hosphan within 24 hours after death. To the Funeral Director After the funeral by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner stated. 29c. License number 29d. Date/signed (Month, Day, Year) 29b. Signature and title of certifie cause of death (Item 23a) (Type, Print) Name and address of person 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2008 Registrar AUG 1 4

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 15, 2008 9:36 P Paradise August Leon Myron /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21823 White Oak Drive Washington Hagerstown 5. Social Security Number 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Davs Months Hours 1 X M 2 □ F 193-12-4894 Director 84 MARCH 10. 1924 PENNSYLVANIA Usual Residence of Decedent 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10h County 10d Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at HAGERSTOWN 1 ☐ Yes 2 XNo MARYLAND WASHINGTON Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21740 10114 SHARPSBURG PIKE U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Black, White, etc. 1 X Yes 2 No 1943− If Yes, Give Year or Dates: 1946 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: ò Specify: 3 \ Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 5+ **PROFESSOR** UNIVERSITY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARC A. PARADISE EDNA M. CORBY 0 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8581 MANSFIELD COURT, MIDDLETOWN, MARYLAND THOMAS PARADISE, SON 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 ment of F tant: If ite 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Department of Important: If any injury or 8/18/2008 STAUFFER CREMATORY FREDERICK, MARYLAND 5 Other (Specify) 4 Donation 22. Name and Address of Facilit Bast-Stauffer Funeral Home, P.A. 10-Paul M. Dean 7606 Old National Pike, Boonsboro, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical as t . nse s IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4□Pregnant at time of death 5 ☐ Other (specify) 1 □Yes 2 □ No s been signed by the should be detached 9 Unknown Part II. Other significant sonditions contributing to death, but not resulting in the underlying, cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes Completed Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an page 2 autopsy performed certificate 1∐ Yes Hospital or Attending Physician: director 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) son's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes 2 ☐ ER/Outpatient 3□ DOA 2 1 ☐ Inpatient this residence 28a. Date of Injury (Month, Day Year) funeral 28d. Describe how injury occurred 27. Magner of Death 28b. Time of 28c. Injury at Work? Certification: Natural 2 Accident Injury 5 Pending investigation 1 ☐ Yes 2 ☐ No Funeral Director: tely filled in by the 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) within 24 h 29b. Signature and title of certifier 29c. License number Tol 29d, Date signed (Month, Day, Year) death (Item 23a) (Type, Print) 30. Name and address of person y 31. Date filed (Month Pay, State 2008 18 Registrar

DHMH 17 Rev 1/2001

State Registrar MEMORIAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

BRA MD 32 Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene amend #1Per Phy Per FH C883 9/25 08 JH Registrar Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Katherine Katherine Marie Porter August 2ď8 3:50 P Potter /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick Frederick Frederick Memorial Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Feb. 13, 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1 □ M 2 🖵 F 40 1968 Virginia 218-74-8623 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Markett Examiner must be notified at once. 1∩a State 10c. City, Town or Location 10d. Inside City Limits 10h County 1 ☐ Yes 2 XNo Director New Market Maryland Frederick 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code U.S.A. 21774 6655 Longbeach Court Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ∐Yes YMNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes YNO Specify: ò Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Health Care Administrative Assistant 17. Father's Name (First, Middle, Last)
Hariton
Harinton Moschonas 18. Mother's Name (First, Middle, Maiden Surname) Be (Patricia Cheris ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6655 Longbeach Court, New Market, MD 21774 Derek L. Potter, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Durial 2 ☐ Cremation 3 ☐ Removal from State St. Paul's Cemetery Aug. 28, 2008 Point of Rocks 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses ^{22. Name and Address of Facility} Keeney and Basford PA Funeral Home MO0255 106 East Church St., Frederick, MD 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one call se on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** erchicl disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Dise to for as a considerors off Hospital or Attending Physician: The law requires that the death certificate be executed nisue sician and burial-tran Due to (or as a co Division of Vital Records, P.O. Box 68760, the attending physician Physician/Medical the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☑ No Day Year Pregnant at time of death 5 Other (specify) signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably director, page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 2 No 1∏Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) cal 29a. Certifier completely (Check only one) and manner stated. within 2 To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier $M\Omega$ D 67210 August 23, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KniRA mederick, mo 400 W Konis 31. Date filed (Month, Day, 32 Registrar's Signature State Registrar AUG 2

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Physician Month Year OUINN RUTH CATHERINE 12:40P M August 9 2008 /Medical 4a. Facility Name (If not institution, give street and number, 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Olney Montgomery Montgomery General Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, March 2 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Hours Days Months 1 □ M 2 🗷 F 84 207-16-3651 New York **Director** 1924 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Exercit or must be rediffed at 1 ☐Yes 2 No Director Rockville Md. Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 20853 United States 13109 Superior Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 □Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Electric Company Secretary 12 is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked offix any lightly or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Petty Frank Mary Frances Edward Jacob ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13109 Superior Street, Rockville, Md. Carol Anne Tharp / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1. Surial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cem. 8/13/08 Silver Spring, Md. 22. Name and Address of Facility
Muriel H. Barber Funeral Home 21. Signature of Funeral Service Licensee mure P. O. Box 5038, Laytonsville, Md. 20882 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leauing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and burial-tran Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) □Yes 2 No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death ≥ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was an autopsy performed?
Yes 2 No page 2 2 🗆 No 1 ☐ Yes 1 ☐ Yes Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 24 hours after death Puneral Director; 6 ☐Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) the To the within 7 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 165292 August 9, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 18101 Prince Philip Dr., Olney, Md. 20832 32. Registrar's Signature State Registrar

Registrar

State

David Allen, M.D.

31. Date filed (Month, Day, Year)

AUG 1 8 2008

32. Registrar's

25500 Point Lookout Road, Leonardtown, MD 20650

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

Physicia /Medic Examin

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Reckey Mared Box 68760,

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Examin	er	4a. Facility Name (If not institution	on, give street and num	nber)		4b. City, Tow	n, or Location	of Death			ounty of Deat	1
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Department or treat and worked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	þ	11. Marital Status 1 □ Never Married 2 🕱 Ma 3 □ Widowed 4 □ Divorce	Armed For 1 ☐ Yes If Yes, Give	² XNo		Vas Decedent Yes, specify □Yes 2X			ecify Yes or N Rican, etc.)		. Race - Ame Black, White pecify: Wh	e, etc.
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27 ls		Frank E. Rocke	y/Husband		1705	Grani	te Road	d, Da	rlingt	on, MD	210	34
nt; If iten		20a. Method of Disposition 1 X Burial 2 □ Cremation 4 □ Donation 5 □ Other (State	lace of Dispos emetery, crem te Rid	natory or other	place)		Date /2008		a, PA	Town, State
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	ter de Items iner n	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 M Married 1 □ Yes 2 M No	 Was Decedent of Hi If Yes, specify Cuba 	an, Mexican, Puerto Ric	can, etc.)	Black, White,	
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Ba	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee	22. Name and Addres Hicks Home 103 W. Sto	for Funera ckton Stree	als, P.A. et. Elkto	on, MD 21	1921
ľ			23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.					Approximate Interval Between Onset and Death
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Division or Vital Records, P.O. Box	r Atte ter dea irecto irecto	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office	28	f. Location (Street City or Town, St	t and Number or Rur tate)	al Route Number,
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	1.		30. Name and address of person who completed cause of death (Item 23a) (Ty	pe, Print)		rda 11	1 310	2 1
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DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear **Physician** Victor T. Reynolds A^{M} August 22. 2008 1:15 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Glade Valley Nursing Center Frederick Walkersville 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) Illinois 7. Age (In yrs. last birthday) 5. Social Security Number Funeral 6. Sex Months Days Hours Min. 1 X M 2 □ F 92 July 14, 1916 335-01-3782 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 23a or 28a-f show event, the Medical Examiner roust be notified at 1 X Yes 2 ☐ No Director Maryland Frederick Walkersville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 56 West Frederick Street Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No World If Yes, Give "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 Is marked other than "natural", or ite 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify White þ Specify. War II 3 N Widowed 4 □ Divorced Year or Dates Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Executive Residential Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic evonce. Fern J. Lewis Benjamin Y. Reynolds 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10553 Edwardian Lane, New Market, Maryland 21774 Dwight Reynolds / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 23, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Keeney & Basford P.A. Funeral Home 21. Signature of Funeral Corvice 106 East Church Street, Frederick, M01433 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Aprinc CUMBERTUR HARRE PAILURE PUR 10 **Physician** TN. /Medical Due to (or as a consequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) physician Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No P.O. 9 Unknown 9 Unknown signed I 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, <u>۾</u> icate has been significated by 27 No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate Division of Vital 1 □Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2√No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To ieral Director: After th 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 TYes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 10 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

Registrar DHMH 17 Rev 1/2001

State

1/211

31. Date filed (Month, Day, Year)

AUG 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WRKA

2008

32. Registrar's Signature

110FAG

State of Maryland / Department of Health and Mental Hygiene State Registra MEND#10f, 196 perINF, 8-15-08, BW, McGertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Lois Rae STUPPEL 2008 4:30 A August 7 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Silver Spring Montgomery <u> Holy Cross Hospital</u> Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 ☐ M 2 💢 F Director 578-52-9552 July 6, 1940 Washington, DC 68 Usual Residence of Decedent r 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Director Maryland Montgomery Silver Spring 10f. Zip Code 20901 10e. Street and Number 10g. Citizen of What Country? ms 23a or r must be r 1143 Loxford Terrace United States death \ Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 7 is marked other than "natural", or items traumatic event, the Medical Examiner me 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify ģ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Shaare Tefila Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Religious School Secretary Synagogue permit. Pages 1 and 2 should be filed v Department of Health and Mental Hygie Important: If item 27 is marked other i any Injury or other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Lieberman Max Waschler ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2090119a. Informant's Name/Relationship (Type. Print) 1143 Loxford Terrace, Silver Spring, MD 20902 Norman Stuppel, Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Shaare Tefila Cemetery 08/10/08 Adelphi, MD 21. Signature of Finer. Service Licensee 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, 20012 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cardiogenic Shock Physician /Medical Due to (or as a consequence of): Examiner Acute Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Cardiomyopathy that the death certificate be execute burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4□Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Upper Gastrointestinal Bleeding 2 No 3 Probably 4 Unknown 1 Tes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Severe Anemia 24a. Was an has autopsy performed?

1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 27 No 1 Tinpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending investigation ne Hospital or Attendii n 24 hours after death. he Funeral Director: A pietely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical within 24 hor To the Fune (Check only one) and manner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) 2 D 0063343 08/07/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

Irina Ruban, M.D.,

AUG 12

2008

31. Date filed (Month, Day, Year)

32 Registrar's Signature

1500 Forest Glen Road, Silver Spring, MD

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year 5:00 A M 2008 Physician August 6, Burton Stanley Sternburg /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Chevy Chase 5600 Wisconsin Avenue #506 Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year)
Apr. 22, 19 If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Months Days Hours 1 ☑ M 2 □ F Massachusetts 1928 Apr. 80 022-20-8895 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location death with the Maryland 10b. County 10a. State if than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1X Yes 2 No Director Chevy Chase MD Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 20815 5600 Wisconsin Avenue #506 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Armed Forces? 1⊠Yes 2□No Korean If Yes, Give War Pages 1 and 2 should be filed within 72 hours after on the file of Health and Mental Hygiene. 1 Never Married 2 Married 1 □Yes 2 No Specify: Specify. If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 White ģ 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Court System 5+ Judge 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ida Paris Alexander Sternburg ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Chevy Chase, MD 20815 5600 Wisconsin Avenue #506 Mildred Sternburg - Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If its any Injury or o once. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8/11/2008 Clarksburg, Maryland Garden of Remembrance 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ldward Sagel Funeral Direction, 1091 Rockville Pike Rockville, 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic Lung Cancer Physician disease or condition resutting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-trar the attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Dav in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) s been signed by the s 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate has page 2 s 2 🗆 No 1 ☐ Yes 1 🗆 Yes 2 🔯 No 26. Place of Death (Check only one) 25. Was case referred to medical director. Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1∐ Yes 2∏ No Certification: To this 28d. Describe how injury occurred After thi funeral of 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 27. Manner of Death Injury 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No ours after death.

neral Director: A
filled in by the fu death. 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 7, 2008 D33293 30 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5454 Wisconsin Avenue #1300 Chevy Chase, MD 20815 Frederick P. Smith, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 12 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar AMEND#20bper F.	State of Maryla C-22 PMW M-0	and / Depa b <i>Cei</i>	artment of I rtificate of	Health and I Death	Mental Hyg	eg. No. 2008	27622
	Physici	on	1. Decedent's Name (First, Middle, La	st)				2. Date of Deat	h	3. Time of Death
	/Medi	cal	An Facility Name (16 and table 15)	Ida SOLODCHI	K				9, ^{Day} 2008 Year	2:22 P M
,	Examir	ier	4a. Facility Name (If not institution, giv Holy Cross Hospi				or Location of Death er Spring		4c. County of Death Montgome	
	Funeral Director			6ex 7. Age (In y. 80	rs. last birthday) Yrs.	If Under 1 Year Months Days			1	nplace (State or Foreign intry), Russia
	Maryland a-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Montgol		City, Town or Lo	cation er Sprinc	9			10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 28 ust be not	ral Dire	10e. Street and Number 1400 Fenwick La	ne #814		10f. Zip Code 2091)		og. Citizen of What Cou United Stat	•
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Moderal Even that: ust be notified at once.	Completed by Funeral Director	11. Marital Status 1	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 1 No If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cub I⊡Yes aX No	Hispanic Origin? (S an, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Amer Black, White, Specify: Whi	etc.
Baltimore, Maryland 21215-0036	within 72 h ene. than "natu he Modical	mplete	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12)	ducation de completed) College (1-4or 5+)	I	dent's Usual Occup kind of work done DO NOT use retire 11ege Tea	pation during most of work d)	king	16b. Kind of Business/II Education	ndustry
land 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Solomon Solodo		00	rrege rec	18. Mother's Nam	ne (First, Middle, N		
, Mary	and 2 shoueaith and No 27 Is mai		19a. Informant's Name/Relationship (Inna Solodchik, S	ister	1400	Fenwick l	_ane #814	, Silver	City or Town, State, Zi Spring, MD	20910
timore	Pages 1 tment of H tant: If iten jury or oth		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify)	Removal from State Ga	Place of Dispos cemetery, crem rden of	sition (Name 8–1 natory or other place Remembra	10/1 ance Memo	1/08 rial Par	20c. Location - City or T k Clarksbu	
Bal	permit Depar Impor any in		21. Signature of Funera Service Licer		2	54 Carro		W, Washi	ngton, DC	20012
Ma.	Physician /Medical		23a. Part1. Enter the disease, or companies the companies or condition that the companies of the companies o	one cause on each line. a. Cardiopulmo Due to (or as a conse	nary Arı		ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between Onset and Death
	Examiner	ner	Sequentially list conditions, if any, leading to minibulate cause. Enter Underlying Cause (Disease or injury that initiated events reculting in death). Let	b. Acute Renal	Failure	9				
ď	ficate be executed g physician and s the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Anasarca Due to (or as a conse	equence of):					
	ا من ج	ledical		d Respiratory	Failur	e				
P.O. Box	ine law requires that the death cert ate has been signed by the attendin age 2 should be detached for use a	Physician/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of preg 1 ☐ Live birth 2 ☐ Fe 4 ☐ Pregnant at time o 9 ☐ Unknown	tal death 3	Ectopic pregnanc Other (specify) _	у		23d. Date of deliv Month	very Day Year
rds, F	w requires that been signed t should be deta	ed by Pl	Part II. Other significant conditions of Dementia	ontributing to death but not re	esulting in the un	derlying cause giv	en in Part I.		acco use contribute to t	
		Completed by	Multiple Electro	lyte Abnormal	ities			24a. Was an autopsy perform	prior to co ned? death?	opsy findings available ompletion of cause of
. Vita	certifi	Be	25. Was case referred to medical examiner?	Hospital:v.		Oth	OF:	th (Check only one)	
	Attending Priys It death. ector: After this by the funeral dir	ation: To	1 ☐ Yes 2 ☑ No 27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	Hospital: 1 Nnpatient 2 2 28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Work	4 Li Nursing H	ome 5 ☐ Reside 28d. Describe ho	nce 6 ☐ Other (Speci w injury occurred	fy)
	T P P P	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec	_I home, farm, stre cify)	et, factory, office		28f. Location (Str City or Town	eet and Number or Run , State)	al Route Number,
2	within 24 hours after to the Funeral Direction of the funeral Direction	Medical	one) 2 Medical Exam	vsician: To the best of my kr iner: On the basis of examination of my number stated.	nowledge, death nation and/or inv	occurred at the tirestigation, in my o	me, date and place pinion, death occur	, and due to the ca rred at the time, da	ause(s) and manner as ate and place, and due t	stated. o the cause(s)
	within To the comple		29b. Signature and title of certifie	1	- M		e number 55069		ugust 10, 2	
			30. Name and address of person who c Sirak Lemma, M.D.	ompleted cause of death (Ite , 1500 Forest	em 23a) (Type, P	oad, Silv	ver Sprin	g, MD 2	0910	
	Stat Registra		31. Date filed (Month, Day, Year) ALIG 12 2008	22. Registrar's Sign	nature Space	K)				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2008 **Physician** Month **EARLE** В. **SCROM** August 10, 1:56 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery Funeral Social Security Number Sex 1X M 2□ F . Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 219-36-8257 Director 29,1929 December New York Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, I'v. Madical Extraints the notified at once. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Beltsville 1 □Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13202 Taney Dr. 20705 Funeral U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give 1959-71 Year or Dates: 1959-71 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Commander U.S. Navv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Clarence Scrom Benham 19a. Informant's Name/Relationship (Type. Print)
Winifred L. Scrom / Wife 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13202 Taney Dr. Beltsville, Md. 20705 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🛱 Cremation 3 ☐ Removal from State Metropolitan Crematory Aug. 11,2008 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Va. 22. Name and Address of Facility
Donald V. Borgwardt Funeral Home, P.
4400 Powder MIII Rd. Beltsville, Md 21. Signature of Funeral Service Licensee 20705 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Physician disease or condition resulting in death) /Medical as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as consequence of) Iro the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month 5 Other (specify) After this certificate has been signed by the a funeral director, page 2 should be detached ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 24 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of ca 29c. License number 29d. Date signed (Month, Day, Year) 11-08

State Registrar 31. Date filed (Month, Day, Year)

AUG 1 2 2008

32 Registrar's Signature

who completed cause of death (item

Species

23a) (Type, Print) Dpinder Singh,

BOC

		For State State Registrar	te of Maryland /	Depar Cert	tment of H ificate of L	ealth and I Death		giene2 () leg. No.	08	27621
		Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of Death
Physici		Izrail Y. Savitskiy					Month August	7 Day 2008	Year	5:25 A M
/Medic Examir		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Death		T	y of Death	
		12101 Village Square 5. Social Security Number 6. Sex	Terrace # 30		Rockvil If Under 1 Year	.1e If Under 24 Hrs.	8. Date of Birtl	1	gomery	ce (State or Foreigr
Funeral Director		213-59-5232 1⊠ M 2 Usual Residence of Decedent		Yrs.	Months Days	Hours Min.	(Month, Day Aug. 9, 1	(, Year)	Ukrai	1)
aryland show	'n	10a. State 10b. County	10c. City, To	own or Loca	ition				10d	. Inside City Limits 1 ☑ Yes 2 ☐ No
th the M or 28a-f e routifie	Director	MD Montgomery 10e. Street and Number	Roc	kvill	e 10f. Zip Code	-		10g. Citizen of	What Country	
23a	al	12101 Village Square	Terrace # 30	1	20852			U.S.A.		
s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examination and the creditied at	by Funeral	11. Marital Status 12. Wa Ari	s Decedent Ever in U.S. ned Forces?]Yes 2⊠No es, Give ar or Dates:	13. Wa	as Decedent of Hi res, specify Cuba	spanic Origin? (S n, Mexican, Puert Specify:	pecify Yes or No- o Rican, etc.)	14. Ra	ce - Americar ick, White, etc fy: Whit	
nin 72 hou e. In "natura Medical E	Completed	15. Decedent's Education (Specify only highest grade comp	11	(Give ki	nt's Usual Occupa nd of work done of NOT use retired	luring most of wor	king	16b. Kind of E	Business/Indu	stry
1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than wither traumatic event, Ite Ins		17. Father's Name (First, Middle, Last)	nege (1-40/ 54)	Engi	neer	18. Mother's Nan	ne (First, Middle,			iet Army
ould be I Mental narked c	To Be	Yankel I. Savitskiy				Atta Ar	onovna I	dlis		
12 sh hand risan		19a. Informant's Name/Relationship (Type. Pro	- 11		Address (Street a			-		
		Irina Savitskiy / Dau 20a. Method of Disposition 1⊠ Burial 2 ☐ Cremation 3 ☐ Remova	20b. Place ceme	e of Disposit etery, crema	tion (Name of Itory or other place	e)	Date	20c. Location	- City or Town	
it. Pa rtmer rtant: njury		4 □ Donation 5 □ Other (Specify)	Garde		Remembra					D
permit. Page Department of Important: If any Injury or once.		21. Signature of Funeral Service Licensee	Hofo	109	Name and Address ard Sage 11 Rockvi	s of Facility Lanera Lanera	l Direct	ion, I	nc. D 2085	2
		23a Part 1. Enter the disease, or complication shock, or heart failure. List only one cau	s that caused the death. L se on each line.	o not enter	the mode of dyin	g, such as cardia	or respiratory ar	rest,	ls ls	pproximate nterval Between
Physician		Immediate Cause (Final disease or condition	Pneumonia							Days
/Medical examiner		resulting in death)	Due to (or as a consequent	ce of):						
.xammei	<u>.</u>	Sequentially list conditions, b	Metastatic 1		Cancer				6	Months
led ssit	nine	Sequentially list conditions, if any lea line to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to for as a consequent	ce off):						
ricate be executed physician and s the burial-transit	dical Examiner	that initiated events resulting in death) Last	Due to (or as a consequent	ce of):						
ing phy as the	Medic	IF FEMALE:					_	1		
The taw requires that the death certific ate has been signed by the attending p bage 2 should be detached for use as s	Physician/Me	23b. Was decedent pregnant in the past 12 months?	res, outcome of pregnancy ☐ Live birth 2 ☐ Fetal de ☐ Pregnant at time of deatl ☐ Unknown	ath 3□I	Ectopic pregnancy Other <i>(specify)</i>				ate of delivery flonth D	/ lay Year
signed by	þ	Part II. Other significant conditions contributi	ng to death but not resultin	g in the und	lerlying cause give	en in Part I.		obacco use cor res 2 □ No		cause of death?
: The law requir cate has been s page 2 shouid I	Completed							sy med?	prior to comp death?	sy findings availab
rtificate tor, pag	Be C	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes ath (Check only o	2 <u>k</u> d No ne)	1□Yes 2	□N0
ysic is ce direc	To B	examiner? 1 ☐ Yes 2 ☒ No Hospita	l: 1 ☐ Inpatient 2 ☐ ER	/Outpatient	3 □ DOA Othe)r.	lome 5 🔀 Resid		ther (Specify)	
Affe	ation: T	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigation	t. Date of Injury (Month, Day, Year)	b. Time of Injury	28c. Injury Work		28d. Describe h			
5 # 5 =	Certification:	a □ Puiside 6 □ Could not be □	Place of Injury - At home building, etc. (Specify)	, farm, stree	et, factory, office		28f. Location (S City or Tox		nber or Rural	Route Number,
F F T S	Medical (29a. Certifier (Check only one) 1 Certifying Physician 2 Medical Examiner: C	To the best of my knowle in the basis of examination manner stated.	dge, death and/or inve	occurred at the tirestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) and i date and place	manner as sta e, and due to t	nted. he cause(s)
vithin 2 To the comple	Me	29b. Signature and title of certifier	1184	711	29c. Licenso			29d. Date sigr		
3		100	- (/	in	D3486	U		Augus	t 7, 2	800
		30. Name and address of person who complet	0		. 1	nhom M	20704			
		Oleg Shpak, MD 947 31. Date filed (Month, Day, Year)	0 Annapolis 32 Registrar's Signature			inham, MI	20/06			
Sta Regist		AUG 12 2008	32 Registrar's Signature	dos	dis					

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year **Physician** OLGA SWINSON 08 10 2008 10:05 A. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery County Holy Cross Hospital Silver Spring 5. Social Security Number 7. Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) 6. Sex **Funeral** Year) Days Hours Months Min. 1 □ M 2 🛛 F 07/06/1930 78 Director 578 44 2801 D.C. Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State show 1 ☐ Yes 2 📉 No er than "natural", or items 23a or 28a-f ships to Neulcal Example in unit be notified Director D.C. Washington death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20001 901 NEW JERSEY AVE NW United States Funeral of Health and Mental Hygiene.

'Item 27 is marked other than "natural" ~-- other traumatic event Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 No 14. Race - American Indian, Black, White, etc. 1 □Yes 2X If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No . Specify: Specify: BLACK Completed by 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) FEDERAL Elementary/Secondary (0-12) College (1-4or 5+) GOVERNMENT CLERK 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Gibson Maurice Williams ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1836 Metzerott Rd. #1918 Adelphi, Maryland DAUGHTER Bonita Shelby 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
Important: If Ite
any injury or ot
once. 1 Burial 2 □ Cremation 3 □ Removal-from State 08/20/2008 Triangle, Virginia 5 ☐ Other (Specify) 4 Donation Quantico National 22. Name and Address of Facility John T. Rhines Funeral Home, LLC matur of Funeral Service Censee 3005 12th Street NE Washington, DC 20017 Approximate Interval Between Onset and Death Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mediate Cause (Final **Physician** if mediate Cause (rease or condition resulting in death) SEPSIS /Medical Due to (or as a consequence of): Examiner GANGRENE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be execute burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the phy nding p. se as t IF FEMALE: nse 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗓 No Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by g a HYPERTENSION 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? PERIPHERAL VASCULAR DISEASE 24a Was an autopsy performed? Yes 24 No page 2 □ No 1 ☐ Yes 1 ☐ Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 2 X No 2 ER/Outpatient 3 DOA funeral dir Certification: To 1X Inpatient 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) Injury 1 X Natural 5 Pending ours after death.

neral Director: A
filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D56691 08/10/2008 30. Name and add ass of person who completed cause of death (Item 23a) (Type, Print) 12107 HERTIAGE PARK CIRCLE SILVER SPRING, MARYLAND 20906 GHOUSIA SULTANAY 31. Date filed (Month, Day, Year) 32. Registrar's Signatu State AUG 1 3 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Aug Day 08, 2008 **Physician** Grace Lillian Snooks 11:15A™ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner St. Mary's County St. Mary's Hospital Leonardtown Birthplace (State or Foreign Country)
 New York If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In vrs. last birthday) 5. Social Security Number **Funeral** Months 1 ☐ M 2 👿 F Yrs. 96 577-01-2704 Dec 22, 1911 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Martal Hygleine. Inportant: if Item 21s marked other than "natural", or items 23a or 28s-f show Important: it Item 27 is marked other than "natural", or items 23a or 28s-f show any injury or other traumatic event, the Me-r-al Examiner must be notified at any injury or other traumatic event, the Me-r-al Examiner must be notified at 1 □ Yes 2 X No MD St. Mary's County Lexington Park Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20653 USA 21451 Lynn Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 2 should be filed within 72 hours after and Mental Hygiene. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Operator Telephone Company 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charlotte Marvill Richard J. Snooks, Sr. ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Richard J. Snooks, III 14290 Chapel Lane, Leesburg, VA 20176 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State National Crematory 08/15/2008 Falls Church, VA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Demaine F.H. 5308 Backlick Rd, Springfield, VA 22151 ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use of each line. 23a. Part1. Enter the disease, or complica shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death) Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Year Month Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II/ Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes Νo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 XNo 24a. Was an 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 ☐ ER/Outpatient 3□ DOA ٩ uneral 28b. Time of 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury 28c. Injury at Work? Certification: 1 Natural
2 Accident Iniury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No Director: 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the beat of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) d title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature who completed cause of death (Item 23a) (Type, filed (Month, Day, Year) State AUG 1 4 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 14, Day 2008 Month P_{M} **Physician** 7:03 August McKenzie Ann Somerville /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Hospital St. Mary's Leonardtown If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 □ M 2 🕱 F Months Hours August 14,2008 Director 5 Maryland 40 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ral", or items 23a or 28a-f show Exa⊞iner must be notified at Maryland St. Mary's 1 ☐ Yes 2√2 No Director Lexington Park 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with Hyglene. 46352 Columbus Drive 20653 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black. White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Completed by Specify: Black 3 ☐ Widowed 4 ☐ Divorced "natural", d other than "natura 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked Jamar T. Somerville Ashley Christina Clarke 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any injury or other traum once. Hollywood, MD 20636 Ashley Christina Clarke /Mother P.O. Box 164 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State August 19, 2008 St. John's Catholic Hollywood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Cemeterv nate of Furjeral Service 22. Name and Address of Facility Mattingley-Gardiner Funeral Home, P.A. P.O. Box 270 Leonardtown, MD 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheck, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** BULMONARY HYPOPLASIA /Medical Due to (or as a consequence of) Examiner MULTICYSTIC DYSPLASTIC KIDNICYC BILATERAL if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed and Due to (or as a consequence of) physician Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown signed by <u>م</u> Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No certificate has Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 🕅 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 0 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: or Attending Division Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No thours after death.

"uneral Director Pely filled in by the fi death. investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier DR.BORRA D0066650 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHU BORRA, MD. ST-MARY'S HOSPITAL, LEONARDTOWN, MD 31. Date filed (Month, Day, Year) 2008 AUG 19 Registrar

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Amgust **Physician** 1005 M EUGENE SCOTT /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Talbot Hospital at Easton Lastor Vemorial If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 M 2 □ F 221-28-0130 Director AUG 20, 1944 MARYLAND 63 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ms 23a or 28a-f show must be notified at 1XYes 2∏No Director MD TALBOT EASTON 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 SOUTH PARK ST. 21601 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 ☐ Never Married 2 Married ō 1 ☐ Yes 2 XNo WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) other than Elementary/Secondary (0-12) College (1-4or 5+) 12 0 SALESMAN PRODUCE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be is marked HOWARD SCOTT BESSIE RIELY ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Item 27 i CHARLOTTE P. SCOTT/WIFE 9 SOUTH PARK ST., EASTON, MD 21601 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of P
Important: If Ite
any injury or ot 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 8/10/2008 STEVENSVILLE, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final stage Ind Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed and that initiated events resulting in death) Last attending physician Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death Month Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes page 2 should Be Completed)ISE ase 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy performed? Yes 21200 ALCOHOL this certificate 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t or Attending 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No death. the Director; 3 ☐ Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d filled in by 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely and manner stated.

Registrar

29b. Signature and the

31. Date filed (Month, Day,

Olato Kun

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Year AUG 1 1 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

wayou!

32. Registrar's Signature

DHMH 17 Rev 1/2001

Baltimore, Maryland

Division or Vital Records, P.O. Box 68760.

29c. License number

SWASHINGTON

29d. Date signed (Month, Day, Year)

MA

State of Maryland / Department of Health and Mental Hygien 🤊 🛭 🕦 🖯 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 16, 2008 4:30 August EMELIE LURENE SLACK /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner WASHINGTON REEDERS MEMORIAL HOME BOONSBORO 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours 1 □ M 2 🛛 F Months Days 172-28-1853 NOV. 21, 1936 PENNSYLVANIA Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location r 28a-f show notified at 10a. State 10b. County 1 X Yes 2 □ No Directo MARYLAND KEEDYSVILLE WASHINGTON 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ns 23a or must be r 21756 U.S.A. 42 NORTH MAIN STREET · death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 X Married ö 1 ☐ Yes 2 🔀 No Specify þ 3 ☐ Widowed 4 ☐ Divorced WHITE "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) th and Mental Hygiene.
7 is marked other than "natu traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) altimore, Maryland 2121 Elementary/Secondary (0-12) College (1-4or 5+) 12 HOMEMAKER OWN HOME 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be and 2 should be OSCAR BURT RHEA HORNING Slack, 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau once. P.O. BOX 86, KEEDYSVILLE, MARYLAND LARRY P. SLACK SR./SPOUSE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State 5 ☐ Other (Specify) 4 □ Donation 8/18/2008 STAUFFER CREMATORY FREDERICK, MARYLAND 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME neral Service Licensee 21. Signature of b 7606 Old National Pike, Boonsboro, MD Paul M. Dean complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest only one cause on each line. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease shock, or heart failure. I List only Immediate Cause (Final disease or condition resulting in death) Smell **Physician** - Cu Lamo /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) physician a s the burial-1 Division or Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 410 Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 100 ပ 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: I Director: After to in by the funeral 1 Alatural Injury 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 24 hours a Medical 29a. Certifier 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the F and manner stated To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) attmo P16819 44417, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301-739-7100 340 MILL STREET, HAGERSTOWN, MARYLAND 21740 VANSANT DATTA Registrar's Signature 1 8 2008 Registrar

		4	For State Registrar		State	e of Ma	aryland		artment of F ctificate of a	lealth and N <i>Death</i>		giene Reg. No. 2	11118	27630
			1. Decedent's Nam	e (First, Middle	, Last)						2. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic	al .	David			٧.			Sommer		August	11,20	008	0145 _M
	Examin	σı	4a. Facility Name (4b. City, Town, o Annapo1:	r Location of Death	1	ĺ	unty of Death Arund	۵1
	Francis		5. Social Security N					ast birthday)	If Under 1 Year		8. Date of Birt	h		place (State or Foreign ntry)
	Funeral Director		577-56-25	546	6. Sex 14 M 2□]F	67	Yrs.	Months Days	Hours Min.	Nov 28	, 1940		York
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	filed within 72 hours after death with the Maryland Hygiene. sther than "natural", or Items 23a or 28a-f show ent, the Medical Examinar must be notified at	ō	10a. State MD	Anne A	runde1			napoli						1 ☐ Yes 2 X No
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Examinations and lines and once.			•	3 ☐ Removal i	from State	At 1	Lantic	esition (Name of matory or other pla Cremato	1		Glen	tion - City or T Burnie	,MD
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Ö	tal or safter al Dire	Certification: To	4 Homicide	/		building, e	tc. (Specif	y) 			City or 10	wn, State)		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Medical	29a. Certifier (Check only one)		Examiner: On		of examina			time, date and plac opinion, death occ				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** James V. Searcey /Medical Facility Name (If not institution, give street and number) Town, or Location of Death **Examiner** Wicomico ospio at 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Days Months 1 X M 2 □ F Feb. 8, 1923 Director 221-10-3771 Alabama Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 □ No Director MD Wicomico Delmar 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 13 W. Elizabeth Street 21875 U.S.A. Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔼 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 white Specify: Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8 Electrician & Plumber Plumbing & Heating 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John V. Searcey Virgie Doyle ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 W. Elizabeth Street Delmar, MD 21875 Kathleen Searcey (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Stephens Cemetery Aug. 13, 2008 Delmar, Delaware 22. Name and Address of Facility
Short Funeral Home
13 E. Grove Street 21. Signature of Funeral Service Licensee Delmar, DE Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final CHRONIC OBSTILLICTIVIE FULLUDIVITAY DRSRASIE **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine The law requires that the death certificate be executed the burial-transit led by the attending physiclan and detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown cate has been signed by page 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe death? 1 ∐Yes After this certificate 2 No 1□ Yes 2 🗆 Physician; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident completely filled in by the Director; 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours a To the Funeral C Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated.

State

31. Date filed (Month, Day, Year) AUG 1 2 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

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CONSTUT HOSPICA 32. Registrar's Signature

29c. License number

2005 8410

29d. Date signed (Month, Day, Year)

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Registrar

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Henneth James Sweatingen
Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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7	4	a. Facility Name (if not institution, give street and risks of		Baltimore Co	·
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Director	- 1	3,0 00 20 1	SPITIZ	3,7,30,0	
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v any	- 1	loa. State			1 Yes 2 X No
and sho	5	Maryland Baltimore Perry Hall	100	. Citizen of What Co	ountry?
Maryl Maryl	0	10e. Street and Number	177	S.A.	
5 72 hours after death with the Maryland nuntural", or items 23a or 28a-f sh	₫	51 Stone Park Place 21236	ify Yes or No-	14. Race - Am	encan Indian, Black,
with with be no	uneral	11. Mantal Status	ican, etc.)	White, etc	
death rr iter	Ĕ	1 X Never Married 2 Maintel 1 Yes 2 X No		Specify: Wh	nite
after all', o	by F	3 Widowed 4 Divolced or Dates: 140 December 1 Level Occupation (Give kind of wol		16b. Kind of Busine	ss/Industry
ours		15. Decedent's Education (Specify only highest 5	d)		
O 72 h ru "n cal E	ete	College (1-4 or 5+) 12 College (1-4 or 5+) Computer Tech	l	Compute	er Service
O3(vithin ene.	Completed	Z	First, Middle, M	laiden Surname)	
5-0 led w Hygin		17. Father's Name (First, Middle, Last) Raymond Oates Swearingen Mary Joa	anne W	oodside	
MD 21215-0036 d 2 should be filed within 72 hours th and Mental Hygiene. It is marked other than "mutu anmarite event, the Medical Exam	Be	Ray Morra Garces Sweet 1195 119b, Mailing Address (Street and Number or Ru	ural Route Num	ber, City or Town, S	tate, Zip Code)
D 21 hould nd Ma is ma	유	Ray D. Swearingen/Brother 12Sandpiper Lane, Be	erlin,	Maryland	121811
more, MD 2121 Pages 1 and 2 should be fi nent of Health and Mental 1 nn: If item 27 is marked yr other traumatic event,		20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, expenditory or other place)	Date	20c. Location - Cit	y or Town, State
		crematory or other place)	10 00	Baltimo	ore,Maryland
TO Pages ent of not: I outh		4 Donation 5 Other Specify: BayView Crematory	18-08		
Baltimore, permit. Pages I at Department of Hes Important: If ite injury or other tr		21. Signature of Funeral Service Licensee	ZZULIO	runeral Mara Ma	ervland21214
	İ	21. Signature of Funeral Service Licensee Multiple Market 1009 Harford Road 23a. Part to disease, or conditions that caused the death. Do not enter the mode of dying, such as cardiac or	respiratory arr	est, shock, or heart	Approximate Interval
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, sour as disease failure. List only one cause on each line.			Between Onset and Death
/Medica		Immediate Cause (Final disease a Atherosclerotic cardiovascular disease	se		
√ amine		or condition resulting in death) Due to (or as a consequence of):			
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		IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of d	elivery Day Year
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate better this certificate has been signed by the attending physic	ian/Mec	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnat	ancy	Month	Day
r 68 certi	dicia	past 12 months? 4 Pregnant at time of death 5 Other (Specify)			
BO death	מום	1 Yes 2 No 9 Unknown 9 Unknown	23e. Did	tobacco use contrib	oute to the cause of death?
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inin:	sctor,	25. Was case referred to medical	ing Home 5	Residence 6	Other: Scene
Kysic this	dir	1 V Yes 2 No Impatient 2 Errocupation 28c Injury at Work?		e how injury occurre	ed
of ng P After	funeral	1 27. Manner of Death 20a. Date of Injury			
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/iSi rr Att ter de virect	h by	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town	n, State)	
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Maspital or Attending Physician: The law requires that the death certificate by the Function of the Function: After this certificate has been signed by the creating physician.	lled	determined (Specify)	1	auto (a) and manage	as stated
Hosp 4 hou			nd due to the cand at the time. da	ause(s) and manner ate and place, and c	lue to the cause(s)
the J hin 2	completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred	a actio ano, ac	_	ed (Month, Day, Year)
To Wit	CO			1	
•		O.C.M.E.		August 12	2000
		30. Name and adoress of person who completed cause of death (Item 23a)			
		Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore,	, MD 21201		
		24 Date Fled (Month Obit Chart 7 200032, Red Strar's Signature			-
D	Sta	200,000			
Re	gistı	αι			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Evelyn B. Turner 2008 na 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death 5. Social Security Number Advents i Montgomery Takoma Park Hospital 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Months Days Hours Min. 1 □ M 2 🕅 F 88 6/6/1920 DC 578-24-7667 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 1 Yes 2 No MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2 Smith Village Court 20294 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1X Never Married 2 ☐ Married 1 ☐ Yes 2 TXNo Specify: Specify: 3 Widowed 4 Divorced Black. 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Supv. PUBLICATIONS DIVISION Federal Government 2yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James S. Turner, Sr. Maggie Davis 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3111 Cherry Rd, NE Washington, DC Alma Gibbs/Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 8/16/2008 Landover, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Marshall's Funeral Home 4217 Ninth Street, NW Washington, DC 20011 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Lancer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Year Month Dav 5 Other (specify) 9 Unknown 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩o 1 Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

P.O. Box 68760, Division of Vital Records,

requires that the death certificate be executed To the Hospital or Attending Physician: **Physician**

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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Physician/Medical

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Certification:

Medical

Department of Health and Mental Hygiene. Important; If Nem 27 is marked other than "natural", or items 23a or 28a-f shov any injury or other traumatic event, the Medical Examinar must be notified at

Physician

/Medical

Examiner

and burial-trar

physician

signed by the a

this certificate has al director, page 2 s

within 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral

the attending p

Baltimore, Maryland 21215-0036

State

Registrar

31. Date filed (Month, Day, Year)

AUG 12 20

29b. Signature and title of certifie

4 Homicide

(Check only one)

29a. Certifier

and manner stated

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

65183

Takoma Park

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Avenue, Lampe 7600 Registrar's Signature

			For State Registrar	State	of Marylan	id / Depa <i>Cei</i>	ertment of H tificate of I	ealth and Death		gien o () (Reg. No.	38	27635
	Physicia	an	Decedent's Name (First, Middle June Carroll)				2. Date of De.	10 ^{Day} 200)8 ^{Year}	3. Time of Death 1:05 A. M
	/Medic Examin		4a. Facility Name (If not institution				4b. City, Town, or	Location of Dea		4c. County		1.03 A
1			Anne Arundel			6 . A b : ab	Annap	olis If Under 24 Hrs	2 2 2 4 2	Anne A		
	Funeral Director		5. Social Security Number 243–52–5408	6. Sex 1 □ M 2 🔼 F	7. Age (In yrs. 72	Yrs.	Months Days	Hours Min		3, Year) 936		place (State or Foreign htry) Carolina
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	e-f sh	ctor	MD Anne	Arundel	Ed	gewate:	r					1 ☐ Yes 2 No
	h with the	Funeral Director	10e. Street and Number 61 Beach Dr.				10f. Zip Code 21	037		10g. Citizen of USA		ntry?
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene. Department of Health and Mental Hygene. Importent: If item 27 is marked other then "naturel", or Items 23e or 28e-f show emprishent: If item 27 is marked other then "naturel", or Items 25e or 28e-f show empring or other treumatic event. In Medical Examinar must be notified at once.	Funera	11. Marital Status 1 Never Married 2 Marr	Armed F ed 1 ☐ Yes	2X No		Was Decedent of H	n, Mexican, Pue	Specify Yes or No rto Rican, etc.)	Bla	ce - Americ ck, White,	
	hours a tureli, o	d by	3 Widowed 4 □ Divorced	If Yes, G Year or			1 Yes 2 No	Specify:		Specif	AAT 1	ite
DCUU-C 7	thin 72 e. en "nat Medic	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)	t grade completed	(1-4or 5+)	(Give	lent's Usual Occup kind of work done of DO NOT use retired	ation during most of we f)	orking	16b. Kind of B		dustry
7	iled wi Hygien ther th		17. Father's Name (First, Middle,	(ast)		R	ealtor	18 Mother's Na	ame (First, Middle,	Real Es		
yland	uld be i Mental I rked o	To Be	Samuel Hunt		ts				ances Had	_	,	
Mary	nd 2 shoo lith and N 27 is ma r treums		19a. Informant's Name/Relations: Florence E. T		daughter		ng Address (Street		Rural Route Number			Code)
ore,	iges 1 ar of Hea if item or other		20a. Method of Disposition 1 (XBurial 2 Cremation		n State Ma	Place of Dispo cemetery, crer	sition (Name of natory or other place Veterans etery	(8)	Date	20c. Location	·	
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cords, P.	w requires that th been signed by I should be detach	ρ	Part II. Other significant condition	ons contributing to	death but not res	sulting in the u	nderlying cause giv	en in Part I.				he cause of death?
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ō	Phys this al dii	n: To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Dat	e of Injury	ER/Outpatier 28b. Time o	28c. Injur	y at	Home 5 Resi	dence 6 Ott how injury occu		(y)
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	To the h within 24 To the f	M	29b. Signature and title of certifie				29c. Licens	e number		29d. Date signs	. ,	Day, Year)
0			30. Name and address of person	who completed ca	use of death (Ite	m 23a) (Tyne	Print)	1689		8/	13/	2008
(5)		JAMES WANG,	1490	79 HEA	1th Cen	Print) iter Drice,	Suite	201 , B.	orie Mi	s (07/6
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 4 2008	Beau.	Registrar's Sign	ature football						

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			Registrar 1. Decedent's Name (First, Middle, Last)		Cei	uncate of	Dealli	2. Date of De	Reg. No.	2000	3. Time of Death
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	yland how		10a. State 10b. County	10c. City, T	own or Lo	cation		**		1	0d. Inside City Limits
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	with the	Dir	10e. Street and Number 10990 SHILOH CHURCH ROAD			10f. Zip Code 2066	5./.		_	en of What Cour	
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9	or iter		Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ 1	No		_	Hispanic Origin? (S an, Mexican, Puerl	o Rican, etc.)		Black, White,	etc.
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ğ	filed other rent,	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle	e, Maiden S	Surname)	
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altimore,	ë = 5 ë		1 XBurial 2 ☐ Cremation 3 ☐ Removal from State			sition (Name of natory or other place OH CEMETER)				URG, MAF	
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DIVISION	r Atte er de; recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Inju	ury - At home	e, farm, str	eet, factory, office		28f. Location	(Street and	d Number or Run	I Route Number,
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	To the hospital or Attending Profession 24 hours after death. To the Funeral Director: After it completely filled in by the funera	Medical	29a. Certifier (Check only one) One) ✓ Certifying Physician: To the basis of and manner start and manner start.	f examination	edge, deat n and/or in	h occurred at the ti vestigation, in my	ime, date and plac opinion, death occ	e, and due to the urred at the time	e cause(s) , date and	and manner as a place, and due to	stated. o the cause(s)
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1			30. Name and address of person who completed cause of de	eath (Item 23	3a) (Type,	Print)			/		
1	B		SONG C-CHON, M.D. 7C POS 31. Date filed (Month, Day, Year) AUG 1 5 2008	TOFF	ICE ,	RD. WALL	DORF, MI	2060.	2		
	Star Registra	-	31. Date filed (Month, Day, Year) 32. Registra ALIG 1 5 2008	ar's Signature	X A	seele					
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DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

State Registrar

VRANCEANU

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** 1119 M Linda Vance 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nicus 1a CENTER YenInsula 5AL11641 REGIONAL MEDICAL If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1 □ M 2 😿 F 57 Director 139-44-3885 6/25/1951 New Jersev Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County ed other than "natural", or items 23a or 28a-f shovevent, the Medical Examiner must be notified at 1 XYes 2 □ No Director Middlesex South Plainfield New Jersey 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 736 Clinton Ave. 07080 USA Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. Department of Health and Montal Hygiene.
Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Expension. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married altimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: ģ white 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) office manager Real Estate 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Angela Lacanna Neil Getz ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Leonard Vance/husband 736 Clinton Ave., South Plainfield, NJ 07080 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Rosehill Crematory 8/15/08 Linden, NJ 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Licensee Holloway Funeral Home, Professional Association Dompor 501 Snow Hill Rd., Salisbury, MD 21804 CESP 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final AKUO **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause of Jacobs or Injury that initiated events resulting is double as Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) signed by the a d be detached for 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown certificate has been s rector, page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 **X** No 2 🗆 No 1 ☐ Yes al or Attending Physician; I safter death.
Il Director: After this certifica od in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1X Yes 2 ☐ No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 X Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled it 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and tiple of ce 29c. License number 29d. Date signed (Month, Day, Year) 1450497 8/10/08 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Carrell St DNyder 31. Date filed (Month, gistrar's Signature Year) State AUG 12 Registrar

State of Maryland / Department of Health and Mental Hygiene? For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Victoria Whitehead Diane 12:15 PM 2008 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 18889 Waring Station Road # 309 Germantown Montgomery Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Year) Months Days Hours 1 □ M 2 🔀 F Yrs. 62 Feb. 14,1946 Washington DC Director 579-62-9290 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any lighty or other traumatic event, the Modical Experiment research once. 10d. Inside City Limits 10a. State 10c. City, Town or Location 1 ☐ Yes 2 No Director Germantown MD Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20874 18889 Waring Station Road #309 Funeral . Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married 1 ☐Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Administrative Assistant 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mortimer Leyden Whitehead Virginia Wilhelmina Wesner 2 Sister, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 18810 Liberty Mill Road, Germantown, MD 20874 Virginia Whitehead Beach / 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 11, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metropolitan Crematory Alexandria, Virginia 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home, 10 East Deer Park Drive, Gaithersburg, MD 20877 TRACY 40 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) CARDIAL /Medical Due to (or as a consequence of): Examiner Pulmonne Disin hoone Se pentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence oi): the Hospital or Attending Physician; The law requires that the death certificate be executed Exami the attending physician and ched for use as the burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 3 Ectopic pregnancy cate has been signed by the atte page 2 should be detached for a Month Year Day 5 Other (specify) 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Yes 2 No 3 Probably Completed 24a. Was an autopsy performed? 1 □ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐No certificate within 24 hours after death,

To the Funeral Director: After this certific completely filled in by the funeral director, it Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 29a. Certifier 1 🗲 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 00053213 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dr. Monica Howard M.D. 20528 Boland Farm Road #103 Germantown, MD 20876 31. Date filed (Month, Day, Year) 320Registrar's Signature State AUG 12 2008 Registrar

08-06112	
Dianne Pittman White	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 27640

		For State	Certifica	te of	Death					. No.		
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ledical Examin		DIANE PIT	FMAN White					A	ugust 10,	2008		0848 hrs
	4	a. Facility Name (if not institution, give	e street and number)	4	b. City, Tov	vn, or Lo	cation of D	eath			nty of Dea	
		4258 Mary Ridge Drive			Randall	istown				Baltir	nore Co	ounty
Euporol	F	o. Social Security Number 6. S	ex 7. Age (In yrs. last birth	day)	If Under	1 Year	If Under 24	4Hrs. 8.	Date of Birth	(MM/DD/Y		Birthplace (State or
Funeral Director		,			Months	Days	Hours	Min.	3/19	110=	Z Fore	eign Country) // C
Director		1011 00 0017	M 2×F 55	Yrs.					2/11/	775	<u> </u>	770
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21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene. marked other than "natural", or items 23a or 28a-f 5th e event, the Medical Examiner must be notified at once	Bec	JAMES R. Stil	VE: C				54518	= 1	William	mi		
112 Id be dents mark	맑	19a. Informant's Name/Relationship (. Mailin	g Address	(Street	and Numbe	r or Rura	al Route Num	ber Gity or	Town, St	ate, Zip Code)
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Baltimore permit. Pages 1: Department of H Important: If it		21. Signature of Funeral Service Lice	nsee	22.1	Name and A	ddress	of Facility	H. K.	1 Hospi	Re!	-Orep	ELANG HEINE
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Physician		23a. Part I. Enter the discase, or confailure. List only one cause on	oplications that caused the death. Do no	t enter	the mode of	dying, s	uch as care	diac or re	spiratory arr	est, shock,	or heart	Approximate Interval Between Onset and
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Sior Attend r death. ector: by the	cat	2 Accident Investig	28e Place of Injury - At home.	7 hrs arm, str	eet, factory,	office b	uilding, etc	. 2	8f. Location	Street and	Number o	or Rural Route Number, City
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Division of Vital Records, P.O. Box 687. To the Hospital or Attending Physician: The law requires that the death certifivith is 4 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as it.	Medical	(Check anly 1 Certifying Physical Cone) Medical Exami	ner:On the basis of examination and/or	investig	ation, in my	opinion	, death occ	urred at	the time, date	and place	, and due	to the cause(s)
To the within To the comple	edi		and manner stated.				e number					(Month, Day, Year)
	Σ	29b. Signature and title of certifier	N		1230			00	OME	1	st 11, 2	
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14 (2)		Theodore M. King, Jr., N	ID. Assistant Medical Exar	niner	111 Pe	enn Str	reet, Bal	timbre,	, MD 2120)1		
	tate	31. Date filed (Month, Day, Year) AUG 1 4 2008	32. Registrar's Signature	All I	,							
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 14, 8:15 p.m. Woods 2008 Tillotson August Evelyn /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Leonardtown St. Mary's St. Mary's Nursing Center If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1□ M 2🏅 F Months Days Hours Pennsylvania 12/18/1921 86 Director 187-16-4931 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a Medical Examinar must be refilled at 1 ☐ Yes 2 🕅 No Director Maryland St. Mary's California filed within 72 hours after death with the 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20619 23299 White Elm Court Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 █️No 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No If Yes, Give Year or Dates: Specify: 2 3 ☐ Widowed 4 🏿 Divorced White Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. 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Edward Jr. M00052 22955 Hollywood Road, Leonardtown, MD Brinsffeld, 20650 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each in Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or conditi-resulting in death) /Medical (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine flat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Directo (or as a nonsequence of) Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of) attending physician Box 68760 Physician/Medical the as IF FEMALE use ves, outcome of pregnancy 23d. Date of delivery 23b. 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DHMH 17 Rev 1/2001

Registrar

AUG 18

2008

ORIGINAL

			State of Maryland / Det	partment of Health and Mental Hy	
		1		ertificate of Death	Reg. No. 2008 27642
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	Physicia		Deborah Ann Wiseman	Augus	t 5, 2008 11:15 A ^M
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Prince George's Hospital	Cheverly	Prince George's
	Funeral	2 1	5. Social Security Number 6. Sex 7. Age (In yrs. last birthda		irth 9. Birthplace (State or Foreign Country) 29, 1953 Washington, DC
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	and w		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or	Location	10d. Inside City Limits
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	ms 2: mus	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	 Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 	lo- Black, White, etc.
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and	be fi	Be	Leonard Wiseman	Ernestine Loc	kridge
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Na	d 2 sl th an 7 Is r traur		Toi Wiseman - Daughter 610	2 Surrey Square Lane #204	Forestville, MD 20747
رن آن	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place of Di	sposition (Name of Date crematory or other place)	20c. Location - City or Town, State
DO.	ages int of t; If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony	Memorial Park Aug 12, 20	008 Landover, MD_
Baltimore,	artme artme ortan injur		21. Sin ature of Fugeral Sin ice kiceosee	22. Name and Address of Facility Stewart	Funeral Home, Inc.
Ba	Dep Imp		The House of Many	4001 Benning Road, NE Was	shington, DC 20019
	S 5-H		23a. Parti. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or respiratory	Approximate Interval Between
	Physician		Immediate Cause (Final	m Organ Faction	Onset and Death
1	/Medical		disease or condition resulting in death) a. Due to (or a, a consequence of);	in garine	
	Examiner		seps.	3	
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	fancreality	
	cuted nd ransi	Examin	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
,09	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of)	1	
	ate be hysici	lical	d. Crough	your	
c 687	death certificate I e attending physi d for use as the b	Physician/Medic	IF FEMALE:		23d. Date of delivery
Box	ath ce ttend or us	an/	23b. Was decedent pregnant 1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	Month Day Year
0	0 0 0	/sic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	5 Other (specify)	
Ω.	The law requires that the tte has been signed by tho age 2 should be detached.		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I. 23e. Di	id tobacco use contribute to the cause of death?
S,	signe signe	by	Sarcidas		☐ Yes 2☐ No 3☐ Probably 4 X Unknowr
Ö	w requires been signed should be	Completed	lanta langua E	nothernation 24a. W	/as an 24b. Were autopsy findings available
3ec	The law cate has l	d d	system from 2	pe	prior to completion of cause of death?
a			Hyperlansion	1 Ye 26. Place of Death (Check on	
Vital Records,	Physician: r this certific ral director,	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outp	Others	esidence 6 Other (Specify)
ō		-: To	27. Manner of Death , 28a. Date of Injury 28b. Tir	ne of 28c. Injury at 28d. Descri	be how injury occurred
on	Attending Phr r death. ector: After they they they they are the funeral	ţi	1 Natural 5 □ Pending (Month, Day Year) Inju	ury Work? M 1 □ Yes 2 □ No	
İSİ	or Attend after death. Director: /	lica	3 Suicide 6 Could not be 28e. Place of injury - At home, farm		n (Street and Number or Rural Route Number, Town, State)
Division	after after Dire	Certification:	4 ☐ Homicide determined building, etc. (Specity)	l City of	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To the best of my knowledge,	death occurred at the time, date and place, and due to or investigation, in my opinion, death occurred at the time.	the cause(s) and manner as stated. me, date and place, and due to the cause(s)
	ne Ho ne Fu ne Fu	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and and manner stated.		
	To the He within 24 To the Fu	Ž	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
			1 / later me	0 130318	18/5/08

State Registrar

31. Date filed (Month, Day, Year)
AUG 1 2 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Wetzstein Year Humphrey OIZS AM August 2008 /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Lanham Prince Georges Doctors Community Hospital 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 □ M 2√F 93 1914 Wash., D.C. Director 577-07-0782 Usual Residence of Decedent be filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examination matter. 1 Yes 2 No Funeral Directo Maryland Prince Georges Landover Hills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4204 72nd. Ave. 20784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 PNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☐ No Completed by Specify: 3 Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry and Mental Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Govm't Printing Offic Secretary 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Humphrey Mary A. Hutchinson 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 end 2 sment of Health an John Wetzstein (SOn) 4204 72nd. Ave. Landover Hills, MD 20784 permit. Pages 1 enc Department of Healt Important: If item 2 any Injury or other once. Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 【ACremation 3 ☐ Removal from State Chesapeake Crematory 8/12/08 Beltsville, MD 5 ☐ Other (Specify) 21. Signatury of Funeral Service License 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 23a. Par 1. Enter the dise e, or o applications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, fnly one cause on each line terval Between nset and Death In mediate Cause (Final disease or condition resulting in death) BRAIN **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physician and for use as the burial-transi Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 5 ☐ Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? this certificate has a director, page 2 s 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 □Yes 2 ☐No 25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After thi 27. Mann Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 □Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0050951 121

State

Zstein, ANN

31. Date filed (Month, Day, Year)

AUG 1 2 2008

REVA - S- GILL

32. Registrar's Signature.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 27644

ziyah Ka'mere W		rs For State	State of	Maryland	/ Departr	ment of Heal icate of Deat	th and Menta <i>h</i>	ai riygierie Reg	201	18 216
Physician	Re	nistrar	e (First, Middle,Last)					2 Date of Death		3. Time of Death 0616 hrs
edical Examine	er	Azis	zah K	amere	Wate	ers		Month August 19,	4c. County of Dea	
	4	a. Facility Name (f not institution, give st	eet and number)	4b. City,	Town, or Location of	Death .	Talbot	
		Easton Wemorial Topical 15 Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign)								
Funeral Director	5	UNKNOWN 1 Months Days Hours Min. 08-06-2008 Maryland								
· ·	_	Usual Residence of Decedent				, Town or Location				10d. Inside City Limit
ow any		Md. Dorchester			1	Hurlock			1 Yes 2 X No	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiera in The Manual "waitural", or items 23a or 28a-f sho Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number			<u> </u>	10f. Zip Code			10g. Citizen of What Country?	
ith the Maryland 23a or 28a-f show notified at once.		7006 Beulah Road				21643			USA	origon Indian Black
with ms 23.	a 1	11. Marital Status 12. Was Decedent Ever in U Armed Forces?				S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. Race - American Indian, Black, White, etc.	
death or ite	וּכִּ		4 Divorced If	1 Yes	2 📉 No	1 Yes	2 No specify:		Specify: B	lack
s after	≥⊢	3 Widowed	ducation (Specify only		ompleted) 1	6a Decedent's Usua	I Occupation (Give k	kind of work done	16b. Kind of Busines	ss/Industry
2 hour	Completed	Elementary/Sec	1	College (1-4 o			orking life. DO NOT	use retired)	None	
036 Ithin 7 ne.	ğ	0				None	40 14-44	le Nama (Eirot Middle N		
5-0 iled w Hygie I other		17. Fathers Name (First, Middle, Last)						's Name (First, Middle, Maiden Surname) ayra Kevon Green		
d be fi fental narked event,	a -	FACT 1411 Advantage Allega (Countries Allega or Pure) Pourte Number City or Town, State, Zip Code)								tate, Zip Code)
Shoul and N	٢		Jenkins/G		ther	304 Pa	rk Ave.	Federal:	burg, Md	.21632
e, M and 2 Health item 2	t	20a. Method of Di	sposition		20b. Pl	ace of Disposition (Nematory or other place		Date	20c. Location - City	or Town, State
ages lant of l			Cremation 3	Removal from	Spr	ing Grov	re Cem.	08-27-08	Denton	, Md .
altin mit. P partme porta	1	22. Name and Address of Facility Bennie Smith funeral Hom 426 Dover St., Easton, Maryland 21601								
E Pe E		Jass	w)	119	nm W	426	Dover S	t., Eastol	n , Mary La est, shock, or heart	Approximate inte
Physician /Medical kaminer	A	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Between Onset an failure. List only one cause on each line.								
		Immediate Cause (Final disease or condition resulting in death) Sudden unexplained death in infancy Due to (or as a consequence of):								
		Convertibility liet conditions b.								
	ner	frany, leading to immediate Due to (or as a consequence of):								
	Examiner	C) (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):								
ecuted and transit	ũ									
ex ial	edical	X UNPENDE	ED						23d. Date of de	livery
		IF FEMALE: 23b. Was decedent pregnant in the 1 I ve hirth 2 Fetal death 3 Ectopic pregnancy Month								Day Year
x 68	sician/M	past 12 mon			nt at time of dea	ath 5 Other (\$	Specify)			
, P.O. Box 6876 res that the death certificate signed by the attending phy be detached for use as the b	Phys		No 9 Unknown	9 Unknow		esulting in the underli	ving cause given in F	Part I. 23e. Did	obacco use contribu	ite to the cause of death
P.O.	by P	Fncenhalitis								Probably 4 🗸 Unkno
IS, F quires en sign	ted	Ence	JIIATICIS					24a. Was		ere autopsy findings ava or to completion of cause
SOFC law re-	Completed								ormed? dea	ath? ✓ Yes 2 N
Vital Records, hysician: The law requir this certificate has been so director, page 2 should.		25. Was case referred to medical 26. Place of Death (Check only one)								
ital sician: is certi	Be	examiner?	F	lospital: 1 Ing	patient 2 🗸	ER/Outpatient 3	DOA Other	Nursing Home 5		Other:
Division of Vital Records, P.O. Box 68766 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the t	5	1 Yes_ 27. Manner of D	2 No Death	28a. Date of	f Injury	28b. Time of Injury			how injury occurred	
	tion	1 Natural	5 Pending Investigati	Fnd 8	3/19/08	Fnd 5:!5	am Yes 2			ed sharing
	Hica	2 Accident Investigation 3 Suicide 6 X Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or or Town, State) 7006 Roullah Rd H1								
	Certification:	Suicide determined (Specify) residence 7006 Beulah Rd Hurlock, MD								
To the within To the comp	Medical		and title of certifier	e of certifier ALALOEV			29c. License number O.C.M.E.		29d. Date signed (Month, Day, Year) August 20, 2008	
	-	Car	ual H							
- a		30. Name and a	address of person who	completed cause ant Medical E	e of death (Iter Examiner	n 23a) 111 Penn Stre	et, Baltimore, N	MD 21201		
<u>ي</u>	itate	71 D 1 C 1 1		lan Bor	gi ar's Signat					
Regis					Willes .	1				
DHMH 17 Rev 1/2	2001		OCME			ORIGINAL				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2:55 PM AUGUST 2008 CLARENCE **EDGAR** WEBBER /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner WASHINGTON WASHINGTON COUNTY HOSPITAL HAGERSTOWN Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ☑ M 2 □ F MARYLAND **Director** 220-34-1199 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f sho event. It effection Examination to confine a 1 ☐ Yes 2 🔀 No Director WASHINGTON MARYLAND BOONSBORO 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 6125 APPLETOWN ROAD 21713 Funeral death 1 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Evantrian, once. 1 X Yes 2 No 1963− If Yes, Give Year or Dates: 1967 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 RAILROAD CARMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be MARY LOU RUNKLES ဂ CLARENCE RAYMOND WEBBER 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21713 6125 APPLETOWN ROAD, BOONSBORO, MARYLAND LOIS Y. WEBBER/SPOUSE 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 1 X Burial 2 ☐ Cremation 3 Removal from State 5 Other (Specify) 4 Dopation 8/19/2008 ROHRERSVILLE, MARYLAND ZION CEMETERY 22. Name and Address of Facility BAST-STAUFFER FUNERAL HOME 21. Signa ure of F Paul M. Dean 7606 Old National Pike, Boonsboro, Maryland 21713 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, o complications that caused the shock, or heart failure. List only one cause on each line complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Ischemic cardiomyopathy **Physician** 2acs /Medical Due to (or as a consequence of): Examiner ears Atherosclerosis Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for an a connectioned of The law requires that the death certificate be executed aftending physician and for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? Day Year 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ Diabetes Mellitu 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed 1 ☐Yes 2 ☐No 1 ☐ Yes 2 ☐ No Attending Physician; within 24 hours after death. **5p the Funeral Director:** After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 27. Manner of Death 1 Watural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Hospital or 124 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Kuttney Sands no 8005, 21 tsu qua 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14214 Paradise Church Road Cynthia Kuther - Sands mo 1 8 2008 31. Date filed (Monti State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 3 Lola Bernice Warner August 0905 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Washington County Hospital Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Hours Months Days 1 □ M 2 🖫 213-40-3221 85 1923 May 23, MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Washington Big Pool 1 ☐ Yes 2 ☑ No 10g. Citizen of What Country? 10e Street and Number 10f Zin Code 13108 Pecktonville Road 21711 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 □Yes & No Specify ⋧ 3 Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) residence Elementary/Secondary (0-12) College (1-4or 5+) homemaker 8th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Lelia Hart Samuel Thorton Miller 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) great-13122 Pecktonville Rd.Big Pool, MD 21711 Steve Swain nephew 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Aug 18, 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 2008 Smithsburg, MD 22. Name and Address of Facility 21. Signature of Funeral Service License Donald Edwin Thompson Funeral Home, Inc Caillyn 77 Clear Spring, MD 21722
enter the mode of dying, such as cardiac or respiratory arrest 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): At Due to (or as a consequence of): Physician/Medical IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Day Year 5 ☐ Other (specify) 9 I Inknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Hhknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy 1 □Yes 2 2No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

execute and burial-trar Box 68760. attending physician requires that the death certificate be the as nse for L P.0. the ģ Division of Vital Records. page 2 s has certificate Hospital or Attending Physician: this After filled in by the

Physician

/Medical

Examiner

Director

Funeral

Be

Examine

Completed

Certification: To

Medical

29a, Certifier (Check only one)

Funeral

Director

7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Evanther must be notified at

nd Mental Hygiene. marked other than

alth and Mental Hv

permit. Pages 1 and 2 st Department of Health and Important: If item 27 Is n any injury or other traun

Physician

/Medical

Examiner

72 hours after

Baltimore, Maryland 21215-0036

24 hours after death. Funeral Director: A To the I

State Registrar

DHMH 17 Rev 1/2001

ARID 31. Date filed (Month, Day, Year) **AUG 18** 2008

29b. Signature and title of certifier



and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description of the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

DO60

29d. Date signed (Month, Day,

Pa

5

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 4:45 p 10 2008 Dean Leroy Work August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner St. Mary's Charlotte Hall Charlotte Hall Veterans Home | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Tuly 17, 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 18 M 2□F Yrs. 1932 Ridgeway, 76 164-24-9933 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a, State 10b. Count or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director Charlotte Hall St. Mary's Maryland 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number United States 29449 Charlotte Hall Road Items 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 1 Yes 2 □ No If Yes, Give Year or Dates: 1957 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced 'natural' 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Federal Government 12 Manager . Pages 1 and 2 should be filed w tment of Health and Mental Hygier tant: If Item 27 is marked other th jury or other traumatic event, ID 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Work Clawson Unknown ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 404 Hickory Circle La Plata, Maryland 20646 Kay F. Work/Ex-Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition TS□ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) permit. Page Department of Important: If any injury or once. Chicamuxen Methodist August 18,2008 Chicamuxen, Maryland 22. Name and Address of Facility211 St. Mary's Ave. LaPlata, MD uneral Service Livens Arehart-Echols Funeral Home, P.A. M01458 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Finat disease or condition resulting in death) DEBILITY **Physician** /Medical Due to (or as a consequence of) Examiner DEMENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? ete hes been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown CORONARY ARTERY DISEASE 24b. Were autopsy findings available prior to completion of cause of death? CANCE PROSTATE 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 🖫 No 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes 2 No 2 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. spital or Attendi rours efter death. nerel Director: A investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours eff To the Funerel Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifier D67788 2008 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KODALI , 29449 Charlotte Hall Rd. Charlotte Hall,MD 20622 LEENA 31. Date filed (Month, Day, Year) State AUG 1 3 2008 Registrar

4b. City, Town, or Location of Death

If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Month, Day, Year JANUARY 7,

CHEVERLY

7. Age (In yrs. last birthday)

10c. City, Town or Location

24

4c. County of Death

1984

PRINCE GEORGES

9. Birthplace (State or Foreign

WASHINGTON, DC

10d. Inside City Limits

Physician /Medical Examiner

Funeral

1 - For State Registrar

5. Social Security Number

217-21-3159

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

6. Sex

1 M 2 F

PRINCE GEORGES HOSPITAL

10b. County

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show

Baltimore, Maryland 21215-0036

Physic /Med Exam

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and

Division or Vital Records, P.O. Box 68760,

1 X 1	MARYLAND PRINCE GEORGES	CLINTON		
	10e. Street and Number	10f. Zip Code		Og. Citizen of What Country?
	9116 SUSAN LANE	20735		JNITED STATES
Funeral	11. Marital Status 12. Was Deceden Armed Forces		nic Origin? (Specify Yes or No- exican, Puerto Rican, etc.)	14. Race - American Indian, Black, White, etc.
by F	1 Never Married 2 Married 1 Yes 2 If Yes, Give Year or Dates:	1 Li Yes 2L X No Spe	ecity:	Specify: BLACK
pa l	15. Decedent's Education	16a. Decedent's Usual Occupation (Give kind of work done during		16b. Kind of Business/Industry
Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	5+) life. DO NOT use retired)		UADEIOUCE
5	12TH GRADE	HEAVY EQUIPMENT	Mother's Name (First, Middle, A	WAREHOUSE
Be	17. Father's Name (First, Middle, Last) CHARLES LOUIS WILLIAMS	1	WENDOLYN (HILL)	· ·
ပ္	19a. Informant's Name/Relationship (Type. Print)	19b. Mailing Address (Street and N		
		THER 9116 SUSAN LANE,		
1	20a. Method of Disposition	20b. Place of Disposition (Name of cemetery, crematory or other place)		20c. Location - City or Town, State
	1 MBurial 2 □Cremation 3 □Removal from Stat 4 □Donation 5 □Other (Specify)	RESURRECTION CEMETERY	Y AUGUST 14,2008	CLINTON, MARYLAND
Ī	21. Any ture of Fund al Sery Licensée	22. Name and Address of THORNTON FIIN	Facility NERAL HOME, P.A	
	EYDIA C. THORNION JOHNSON MO	10583 3439 LIVINGS'	TON ROAD, INDI	AN HEAD, MARYLAND 2
	23a. Part1. Enter the disease, or complications that caus shock, or heart failure. List only one cause on each	ille.		Onset and Deat
		VEHICLE ACCIDENT WITH I	MULTIPLE INJUR	IES
	resulting in death) Due to (or a	s a consequence of):	10200	and a
_	Sequentially list conditions,	as a consequence of):	MULTIPLE INJUR	17
nine	cause. Enter Underlying Cause (Disease or injury	1 200	# HO	
Examiner	that initiated events C.	as a consequence of):		
cal				
Physician/Medical	15.551411.5			
an/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcon 1 ☐ Live birth	2 ☐ Fetal death 3 ☐ Ectopic pregnancy		23d. Date of delivery Month Day Yea
sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	at time of death 5 Other (specify)		
Phy	Part II. Other significant conditions contributing to death	but not resulting in the underlying cause given in	Part I. 23e. Did to	bacco use contribute to the cause of deat
Completed by				es 2万 No 3☐ Probably 4☐Unk
etec			24a. Was a	an 24b. Were autopsy findings ava
фш			autop:	med? prior to completion of caus
e C	25. Was case referred to medical	26.	1 Yes i. Place of Death <i>Check onl or</i>	
o B	examiner? 1 No Hospital: 1 Inpa	atient 2X ER/Outpatient 3 DOA Other:	4 ☐ Nursing Home 5 ☐ Resid	ence 6 Other (Specify)
n: T	27. Manner of Death 1 Natural 5 Pending 28a. Date of I	njury 28b. Time of 28c. Injury at Work?		ow injury occurred DRIVING ATV] E OF ROAD, LOST CONTROL
Certificatio	2 Accident investigation AUGUST8		2 X 1110	
ıţţi	dotormin od 20e. Flace 01	injury - At home, farm, street, factory, office etc. (Specify) STREET	28t. Location (S City or Tow	treet and Number of Rural Route Number of State) ROUTE 301 SOUT
Ce	29a, Certifier 1 X CertifyIng Physician: To the be	est of my knowledge, death occurred at the time, or	date and place, and due to the	END'REE ROAD
Medical	(Check only one) 2 Medical Examiner: On the basis	of examination and of investigation, in the opinion	on, death occurred at the time,	date and place, and due to the cause(s)
Me	29b. Signature and title of certifier	29c. License nu		29d. Date signed (Month, Day, Year)
	1 Bray ends ha	to read D 200)69 A	AUGUST 11, 2008
	30. Name and address of person who completed cause of			
	BRAYENDRA MISRA, M.D. 72	29 HANOVER PKY SUITE A strar's Signature	GREENBELT, MA	RYLAND 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) 2. Date of Death Mopth **Physician** WHITT HILLIP 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Hospice of the Chesapeake-Tate House Linthicum If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
Dec. 25,1940 5. Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Days Hours Months 217-34-7514 67 Virginia Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 10a. State ral", or items 23a or 28a-f show Examiner must be notified at Anne Arundel Millersville 1 □ Yes 2 No MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 769 South Mesa Road 21108 filed within 72 hours after death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? Pay (Was December 1997 No. 3.
Armed Forces? Bay of
1 No. 3 Pigs
1 No. 3 Pigs
1 Year or Dates: Invasion Black, White, etc. 1 ☐ Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ 3 Widowed 4 Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical Commercial Cleaning College (1-4or 5+) item 27 is marked other than other traumatic event, the Me Elementary/Secondary (0-12) Self Employed Company 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be t and 2 should be fi Health and Mental H Iris Nicewonder Ned Whitt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health a Important: If item 27 is any Injury or other tra 769 South Mesa Road, Millersville, MD 21108 Sheila S. Whitt/ Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 11, August 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State Metro Crematory **2**008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Barranco & Sons, P.A. Severna Park Funeral Home 21. Sign to re of Fune I Service Licensee 495 Gov. Ritchie Hwy, Severna Park, MD 21146 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. immediate Cause (Final BRAIN Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) I□Yes 2□No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 (USTATE 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) MOSPICG Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? e Hospital or Attending Pi 24 hours after death. e Funeral Director: After the letely filled in by the funeral Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific ,2008 Um who completed cause of death (Item 23a) (Type, Print) Name and address of pe TA- W 441 ILHARA

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

AUG 1 2 2008

32. Ryjistrar's Signature

				State o	f Maryland	d / Depa	artmen	t of He	ealth a	and Me	ntal Hyg	giene	0000	07650
		•	For State Registrar				rtificat					Reg. No.	/ 11 11 7	3 27650
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	Examin	er	4a. Facility Name (If not institution, PLEASAWNIEW)	furSING	Honz		MT.		,	RROL	_		ARRIL	
	Funeral		14164 (-/1 - 1	6. Sex	7. Age (In yrs. I	ast birthday)	If Under	1 Year	If Under		Date of Birt	h	9. Bir	thplace (State or Foreign
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	pu!		Usual Residence of Decedent 10a. State 10b. County		10c, City	, Town or Lo	cation							10d. Inside City Limits
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	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show adical Examiner must be notified at		1045 Long Corne	er Road				2	21771				ited S	
	ems :	Funeral	11. Marital Status	12. Was Dec		S. 13.	Was Dece	dent of His cify Cuba	spanic Ori n, Mexicar	gin? (Speci n, Puerto Ri	fy Yes or No- can, etc.)		 Race - Ame Black, Whi 	
30	s afte	by Fu	1 ☐ Never Married 2 ☑ Marri 3 ☐ Widowed 4 ☐ Divorced	ed 1 🗑 Yes If Yes, Gi Year or D	2⊡No ve pates: WWII		1 ☐ Yes	2█ No	Specify:				Specify:	White
215-0036	thour salex		15. Decedent	's Education	atos.	16a Dece	dent's Usu	al Occupa	ition		- 1	16b. Ki	nd of Business	/Industry
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<u> </u>	be file	Be	17. Father's Name (First, Middle,	_							First, Middle,		Surname)	
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<u>8</u>	es 1 and 2 should be the the transment of them 27 is marked rother transmatic errother transment of the tran		Pasty Smith /		n-law		Long							and 21771
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Baltimore,	permit. Pag Department Important: any injury o		21. Signature of Funeral Service	Licensee		2	2. Name a	nd Addres	s of Facili	ty Stau	ffer F	uner	al Home	es, P.A.
-	20589		SO But Start Start	4 July	aguand the death								y, Mar	yland 21771 Approximate
	() () ()		23a. Part1. Enter the disease, with shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	n. Do not en	h-a-a	as or dynn	g, such as	A		11031,		Interval Between Onset and Death
*	Physician Medical		disease or condition resulting in death)	a. Due to	(or as a consequ	uence of):	your	ing		150	156			GERES
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687	ficate phys ts the			d										
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m m	death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No		nant at time of d		Other (s						Month	Day Year
о. О	w requires that the dibeen signed by the should be detached	Phy	9 ☐ Unknown Part II. Other significant condition			ulting in the u	anderlying a	rauco dive	an in Part		23e Did t	obacco	use contribute	to the cause of death?
Ś	signed	b	ATRI		BRILL			sauce gree	211 111 1 1211					Probably 4 ☐Unknown
Records,	v requ been should	Completed					-				24a. Was	an	24b. Were	autopsy findings available
Ř	he lay e has age 2	Juno					-				auto	psy ormed?	prior to	completion of cause of
Vital	an: T	Be C	25. Was case referred to medical						26. Place	e of Death	(Check only		, , ,	
<u>-</u>	hysic his ce I direc	To E	examiner? 1 ☐ Yes 2 ☑ No		Inpatient 2				4 🗠 N				6 ☐Other (Sp	ecify)
Division or	ing P		27. Manner of Death 1 ☑ Matural 5 ☐ Pendin	9	e of Injury nth, Day Year)	28b. Time o Injury	of M	28c. Injur Worl	yat k? Yes 2 □	.	3d. Describe	how inju	iry occurred	
S	death ctor: /	icati	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be 28e Plac	e of injury - At he	ome, farm, si			162 2		3f. Location (Street a	nd Number or i	Rural Route Number,
<u>N</u>	after after i Direct	Certification:	4 ☐ Homicide determ	build	ding, etc. <i>(Specil</i>	fy)					City or To	wn, Stat	e)	
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit			ng Physician: To the Examiner: On the										
	the He lin 24 the Fi	Medical	one)	and ma	nner stated.									
	with To	2	29b. Signature and title of contifie	111-		0	28		e number 26	499	;	290. Da	•	nth, Day, Year) 6 - OS
Y			30. Name an ddress of person	who completed as-			Print)	0		- / /			0" 6	
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	Regist	rar	AliG	122.	Par to be	ature J	1000	William Brown						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 08 Voa Physician Whalen 0255 A M Catherine Lucille 2008 10 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner HICOMICS ROGIONAL SAUSBUR 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. Security Number Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 10/1/1922 **Funeral** Days Months 1 □ M 2 □ XF 85 215-12-9388 Vrs Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
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Holloway Funeral Home Professional Association
501 Snow Hill Rd., Salisbury, MD 21804 David H. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMONIA DAYS /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): P.O. Box 68760, led by the attending physician detached for use as the buria Physician/Medical use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 - Ectopic pregnancy Dav 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 \ Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown PEMENTIA has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2200 this certificate 1 ☐ Yes 2 ☐ No Hospital or Attending Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To To the ruce within 24 hours after death.

To the Funeral Director. After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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ZONALD 31. Date filed (Month, Day, Year) State **AUG** 12 Registrar

RAU172 32. Registrar's Signature 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

560 RIVERSIDE DR SALISBURY MD

036576

8/10/08

MD

State of Maryland / Department of Health and Mental Hygierre 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Ам 8 Wilmer 2008 10:30 Carl Bryant /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Fruitland Wicomico 111 Linda Drive If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Hours Min. 1**X** M 2□ F 5-20-1934 Director 214-30-8902 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event. The Mcdical Examinar must be notified at 1 Yes 2X No Director MD Wicomico Fruitland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21826 USA 111 Linda Drive Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Ia marked other than "natural", or Iten any injury or other traumatic event. The Michigal Experimen. ODGs. 1 X Yes 2 □ No 1953-If Yes, Give 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Year or Dates: 1955 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Contractor Own Business 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Nuckles Wilmer Mae 2 Bunyan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 29007 Tannager Way, Eden, Maryland 21822 Lenis Wilhelmi - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-13-2008 Snow Hill, Maryland Bates Cemetery 21. Sinatur of Funeral Service Licensee 22. Name and Address of Facility Bounds Funeral Home Darden 705 E. Main Street, Salisbury, Maryland 21804 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician A -610nary /Medical Due to (or as a consequence of): **Examiner** COPD Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of) Examiner the attending physicien and hed for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Yea in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, δ 1 des 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 312 No Hospitel or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) B 1 □ Yes 3 ☑ No this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation after death.

I Director: After din by the fur 1 Tes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. To the I within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D0053394 Pemberton DR Tos Salisbury, 70101 address of person who completed cause of death (Item 23a) (Type, Print) 1205 MD 32 sistrar's Signature State Registrar

			For State	State	of Maryl		artment of F					/ 111	0.8	27653
			Registrar 1. Decedent's Name (First, Middl)	e, Last)			- Incare or i	Douin		2. Date of De	Reg. No). — ·		3. Time of Death
	Physici		Bertha M. Zuke	rman						Month August	6. Da	2008 ^Y	'ear	2:45 P M
may .	/Medic Examin		4a. Facility Name (If not institution		umber)		4b. City, Town, or	r Location				. County of	Death	
			4620 N. Park A	venue #40)7W		Chevy C	hase				Montg	omer	У
П	Funeral		5. Social Security Number	6. Sex 1 ☐ M 21x F	7. Age (In	yrs. last birthday)	If Under 1 Year Months Days	If Under Hours	Min	8. Date of Bir (Month, Da	av. Year))	. Birthpla Count	ace (State or Foreign
	Director		376-12-0869	1 🗆 M 2 <u>k</u>) F	91	Yrs.				July 2	0, 1	917		ington, DC
	and and		Usual Residence of Decedent 10a. State 10b. County		10c	. City, Town or Lo	cation						10	d. Inside City Limits
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	r 28a	Director	10e. Street and Number	Omery		Onevy	10f. Zip Code				10g. Cit	tizen of Wh	at Count	ry?
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	ems	Funeral	11. Marital Status	12. Was Dec Armed F	cedent Ever i	n U.S. 13.	Was Decedent of H	lispanic Ori an, Mexicar	igin? (Spe	ecify Yes or No Rican, etc.))-	14. Race -	America White, et	
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7	d with giene rr thai	mo	Elementary/Secondary (0-12)	College	(1-4or 5+)		emaker				Ow	n Hom	e	
9	al Hy othe	Be C	17. Father's Name (First, Middle,	Last)				18. Mothe	er's Name	(First, Middle	, Maiden	Surname)		
yland	uld b Ment arked atic e	2	David A. Mille	r				Tes	ssie	Bryk				
0	2 sho	. 19	19a. Informant's Name/Relations				ng Address (Street							
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altillor	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Iniportant: I fleen 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, It a Nedical Extended must be notified at once.		4 ☐ Donation 5 ☐ Other (S		B		om Cong.	on of English		/2008	-		•	ghts, MD
Ö	permi Depar Impor any ir		21. Signature of Fulleral Service	A.	111.	eest 10	Name and Address Ward Sage 91 Rockvi	el Fui	neral	Direc	tion	, Inc	2085	.2
			23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that	caused the c							, FID		Approximate Interval Between
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_	sit sit	ie	Sequentially list conditions, if any, leading to immediate cades. Enter Univerlying Cause (Disease or injury	Due to	o (or as a con	sequence of):								
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	incate be executed physician and s the burial-transit	dical E			(
	g phy as the			a										
5	attending p	sician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	utcome of pre		7 Estania					23d. Date	of delive	ry
	e dear	sicia	in the past 12 months? 1 ☐ Yes 2 🎛 No		gnant at time		Description of Ectopic pregnancy Contract of Ectopic pregnancy Contract of Ectopic prediction of Ectopic predi	у				Monti	n I	Day Year
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> =	nysician: The la his certificate ha I director, page 2	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Uppatient 1	2 ☐ ER/Outpatier	ot 3 TI DOA Othe	or:		(Check only one 5 ☑ Resi		€ □Othor	(Consider	
5	th. Th. Tuneral c	\vdash	27. Manner of Death	28a. Date	e of Injury	28b. Time of				28d. Describe				<i>)</i>
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	ral Di	1 1							4					
0	within 24 bours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical		ng Physician: To the Examiner: On the										
4	ithin (Mec	29b Signature and title of celtifier		niner stated.		29c. Licens	e number			29d. Da	ate signed (Month, L	Day, Year)
,	1		(A)	1	1	w	12890					gust		
	10	-	30. Name and address of person	who completed cau	ise of death ((Item 23a) (Type,		(20)			214			
			Jon M. Wiseman	, MD 541			Avenue N	W #11	l7_Wa	shingt	on,	DC 20	015	
	Sta	te	31. Date filed (Month, Day, Year) AUG 12	2008	Registrar's Si		- A 20							
	Registra	ar	LOG 18	2000	ive .	D. Agas	NED.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Ye ar Month **Physician** PM 15 8005 /Medical 4c. County of Death Examiner OUNTU HAGEES LOWN If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 03/07/1923 rthplace (State or Foreign (In yrs. last birthday) Funeral 1⊠M 2□F NY 85 083-12-9796 Director Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Health and Mental Hyglene.
ant; If them 27 Is marked other than "natural", or Items 23a or 28a-f show ury or other traumatic event, Its Modical Exercites a cast be notified at ury or other traumatic event, Its Modical Exercites a cast be notified at 1 XYes 2 No Director NY Richmond Staten Island 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10301 401 Woodstock Avenue US Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2XINo Specify. White ò Specify: 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Automotive Auto Mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vincent Zito Giovanna Zito ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If Item 27 Is any Injury or other trains Fran Sciulla / Daughter 18644 Keedysville Road, Keedysville, MD 21756 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08/20/2008 | Staten Island, NY St.Peters Cemeterv 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac Street, Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last le entercolitu Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy 5 ☐ Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Disesse 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has briector, page 2 s autopsy 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) hours after death.

Ineral Director: After this ce
y filled in by the funeral direc Hospital: Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death
1 Natural
2 Accident 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier and manner stated within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 0

Registrar
DHMH 17 Rev 1/2001

State

AUG 18

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 132 A M Physician Alston august 25 2008 Ethel Mae /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Baltimore Hospital 0+ If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex **Funeral** Days Min. Months 1 □ M 2√2 F 215-22-7019 83 24 25 MD Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show or other traumatic event, the Medical Examiner must be notifled at 1 XYes 2 No Baltimore NA MD Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Items 23a or U.S.A. 21215 3700 1/2 Columbus Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14 Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after Hygiene. 1 □ Never Married 2 □ Married "natural", or 1 ☐ Yes 2 🛛 No Specify: Black ģ **¾**□ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Continental Can Co. Tow Mow Operator 12th grade nă 1 and 2 should be filed with and Mental Hygier and Mental Hygier and 27 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Annie Mae Reddick Benjamin Hill ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2: Department of Health at Important: If Item 27 is any Injury or other trat 3700 1/2 Columbus Drive, Baltimore, Charles Alston-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Baltimore Co, Md 8/30/08 Woodlawn Sign ure d Funeral Service Licensee 22. Name and Address of Facility, March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, spock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cardiac disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Peripheral Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dus to (or as a consequence of) Examiner or Attending Physiclan: The law requires that the death certificate be executed per Division or Vital Records, P.O. Box 68760,2 and Due to (or as a consequence of) Completed by Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23h. Was decedent pregnant 3 □Ectopic pregnancy Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 donknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 autopsy performed 2 📑 25. Was case referred to medical examiner?
1 → res 2 □ No funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 PER/Outpatient 1 Inpatient 3 DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death.

To the Funeral Director: completely filled in by the f 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

State Registrar

Baltimore, Maryland 21215-0036

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

(Month, Day, Year) AUG 2 8 2008

m.D.

32. Registrar's Signature

D0054482

Sinai Hospital 2401 W. Belvedere Ave

August 25, 2008

Baltimore, MD 21215

08-06261 Badie Artis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 27656

adie Artis		For State	Cei	rtificate o	f Death				j. No.	- 12 =	o ta i
Physician		gistrar Decedent's Name (First, Middle,Last)						Date of Death Month	Day Yea		me of Death 404 hrs
ledical Examine	er	DIWIE CHEST	RTIS		4b. City, Town	or Location o		August 15,	4c. County	of Death	
!	4.	a. Facility Name (if not institution, give str	eet and number)		Capitol H				1	George's	
		505 Suffolk Avenue	7. Age (In yrs.	last birthday)	If Under 1	Year If Unde	r 24Hrs.	3. Date of Birtl	(MM/DD/YYY	Y) 9. Birthplac Foreign	ce (State or
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Director			2 F 60		·					140	Innide City Limits
any		sual Residence of Decedent 0a. State 10b. County	10c. City	, Town or Loca	ition						. Inside City Limits X Yes 2 No
*		MD PRINCE GE	ORGE'S CA	PITOL	HEIGHT	S			g. Citizen of W	l	
ırylanı Sa-f si	影	0e. Street and Number			10f, Zip Co	de		10	g. Citizen of W	mat Country:	
death with the Maryland or items 23a or 28a-f show must be notified at once.	Director	937 ABEL_AVENUE_			2074	3		W Marian Na	USA 14 Bac	ce - American	Indian, Black,
with t		Marital Status	Was Decedent Ever in U Armed Forces?	J.S. 13. W	as Decedent of Yes, specify C	if Hispanic Ori uban, Me xican	gin? (Spec ı, Puerto Ri	can, etc.)		ite, etc.	mid-drift, Education
r item	Funeral		X Yes 2 No			No specify			Specify	BLACK	
after de		3 Widowed 4 X Divorced If	Yes, Give Ye969-197	14Co Docod	ent's Usual Occ	unation (Give	kind of wo	rk done	16b. Kind of E	Business/Indu	stry
hours natur Exam	핗	15. Decedent's Education (Specify only Elementary/Secondary (0-12)	College (1-4 or 5+)	during	most of working	g life. DO NOT	use retire	d)			_
36 in 72 han " tical	mpleted	10th	Sollege (* * * * * * * * * * * * * * * * * * *	MECH	ANIC			1		EMPLOYE	ID
5-0036 led within 7 Hygiene. I other than	O I	17. Father's Name (First, Middle, Last)		_!					Maiden Surnan	ne)	
215 be filed ntal Hy rked o	ا <u>۾</u>	HENRY ARTIS			ling Address (MAR	Y REI	D Poute Nu	mber City or T	own, State, Zi	p Code)
D 21215-0036 Carlo With the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene. T is marked other than "natural", or items 23a or 28a-f she natic event, the Medical Examiner must be notified at once	리	19a. Informant's Name/Relationship (Typ		19b. Mail	ling Address (Street and Nu		CAPT	TOI. HE	IGHTS.	MD 20743
MD d 2 sho lith and m 27 is		ALMA BELL / SISTE	ZR	b. Place of Disp	VALLE Y	of cemetery,	T	Date	20c. Location	on - City or To	wn, State
re, s l an f Hea If iter	-	20a. Method of Disposition 1 X Burial 2 Cremation 3	1	crematory or heltenh	other place)		08-2	9-2008	Chelt.	enham.	MD
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", a injury or other traumatic event, the Medical Examiner.	[21. Signature of Funeral Service License	- 11 D	O	/208	ΙΙΤΤΙ ΔΝ	ID ROA	AD.	SUITL	AND, M	D 20746
		23a/Part I. Enter the disease, or compli	Donald R.	ath. Do not ente	er the mode of	dying, such as	cardiac or	respiratory a	rest, shock, or	heart	Approximate Inter Between Onset a
Physician Tedical		failure. List only one cause on each	h line. Atherosclero								Death
aminer		Immediate Cause (Final disease a or condition resulting in death)	ue to (or as a consequence	e of):	IUIOVAS	carar	<u> </u>				
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	ner	if any, leading to immediate	ue to (or as a consequenc	ce of):							
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e exectian ar	Medical	X UNPENDED	AMENDED 23a,2		,goo3 3	711700	1.1		23d Da	te of delivery	
cords, P.O. Box 68760, law requires that the death certificate be executed has been signed by the attending physician and 2.2 should be detached for use as the burial - transit	Z.	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of p		Fetal death	3Ecto	opic pregna	ancy	Mon		ay Year
Box 687 e death certific the attending ped for use as the	Physician/	past 12 months?	1 Live birth 4 Pregnant at time of	of death 5	Other (Spec						
SOX death e atter	ysic	1 Yes 2 No 9 Unknown	g Unknown				Dist	23a Di	tobacco use o	contribute to t	ne cause of death
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P.O. res that the signed by be detac	d b							24a. W		24b. Were aut	opsy findings avai
rds requi been hould	Completed							aı	topsy rformed?	prior to co death?	ompletion of cause
SCO ie law te has ge 2 s	Ę							1 🗸 Ye		1 ✓ Ye	s 2 N
l Re n: Th tifical or, pa	၂ပို	25. Was case referred to medical			2	6.Place of De				6 🗸 Other	Scene
/ita /sicial nis cer	o Be	examiner? 1 ✓ Yes 2 No	lospital: 1 Inpatient			OA Other	110.0	ng Home 5	be how injury of		. Scene
Division of Vital Records, tal or Attending Physician: The law require is after death. The three of the this certificate has been significant by the funeral director, page 2 should be lied in the present of the control of the cont	F	27 Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Tim	e of Injury	28c. Injury at V		280. Descri	bo non nyany s		
on fendin eath.	9	1 X Natural 5 Pending 2 Accident Investigation	on 28e. Place of Injury -		attact footopy			28f. Location	on (Street and I	Number or Ru	ral Route Number,
ViSi or At fifter d Direct in by	Certification:	3 Suicide 6 Could not determine	be	· At nome, tarm	, street, ractory	, office bandin	9, 010.	or Tow	m, State)		
Di spital cours a filled	الح	4 Homicide determine	177 //	udadaa daath	occurred at the	time date an	d place, ar	nd due to the	cause(s) and m	nanner as stat	ed.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici or night of the funeral director; After this certificate has been signed by the attending physici	1 62	798 Celliel 4 C-4thring Dhysis	r:On the basis of examina	tion and/or inve	estigation, in m	y opinion, deal	th occurred	at the time, o			
To th withir To th	Modical	29b. Signature and title of certifier	and manner stated.			c. License nun			29d. Dat	te signed (Mo	ntn, Day, rear)
	2	250. Gardina and and and	(NG,10			O.C.M.E			Augus	st 16, 2008	
		30. Name and address of person who	completed cause of death	(Item 23a)							
X		Margarita Korell MD. A	ssistant Medical Ex	aminer 1	11 Penn St	reet, Baltin	nore, MI	21201			
	Stat	Of Date filed (Manth Day Your)	32. Registrar's S		ali)						
Regi		AUG 2 8 2008	Believe L	- Parison							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 200 /Medical 4b. City. Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 1 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) 6. Sex 5. Social Security Number **Funeral** Min. 1□ M 2X F Months Days Hours -12-7856 Director -1926 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination or other traumatic event, the Medical Examination or other traumatic events. Yes 2 □ No TIMORR Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 2 📉 No Baltimore, Maryland 21215-0036 Specify. Specify: 3 Widowed 4 □ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Şecondary (0-12) College (1-4or 5+) WZXIZ 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be MA ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) (21VERT 81 133 Gilcoch 100 91200 101 N 571 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 20108 MARY ani Carmel 11 Jamure of Funeral Service Licenses TOLE & EN. UBGRTY 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a constant noce of): **Physician** sem /Medical **Examiner** Salet Sequentially list conditions, if any, leading to immediate cause. Erner underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) sician and burial-transit law requires that the death certificate be exec Due to (or as a consequence of) P.O. Box 68760, attending physician Physician/Medical the IF FEMALE Ise 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for Month in the past 12 months?
1 ☐ Yes 2 Û No
9 ☐ Unknown 5 ☐ Other (specify) signed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ≥ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown cate has been si page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No To the Hospital or Attending Physician: The within 24 hours after death,

To the Funeral Director: After this certificate ha completely filled in by the funeral director, page 1 □Yes 2 🖎 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one Be Hospital Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Aatural 1 ☐Yes 2 ☐No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 1) 57088 AUGUST 25, 2008 Than foon; mi 30. Name and address of person who completed cause of death (Nem 23a) (Type, Print)

Than from 201 ST. (Cur.) Baltimon, mi) 21202 #601

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 8 2008

32 Registrar's Signature

Reg. No. 2008

4c. County of Death

St. Marv's

United States

14. Race - American Indian, Black, White, etc.

United States

Specify: White

Government

5:15 A M

9. Birthplace (State or Foreign

10d. Inside City Limits

1 ☐ Yes 2 ☑ No

Mary Land

August 25 2008 ar

2. Date of Death

. Decedent's Name (First, Middle, Last)

John Thomas Barber, Sr.

Physician

/Medical

P.O. Box 68760. Division of Vital Records,

Bessie A. Miller 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 Darlene Avenue, Linthicum Heights, MD 21090 20c. Location - City or Town, State Baltimore, MD 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23d. Date of delivery Month Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No spital or Attending Physiclan: Thours after death.

neral Director: After this certificate y filled in by the funeral director, pa Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signarare and title of certifler 29c. License number MD D67788 25-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) KODALI, 5505 Bayview Circle Baltimore, MD 21224 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar **ORIGINAL**

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Month Day **Physician** /Medical 4a. Facility Name (If not institution, give street and number) Çity, Town, or Location of Death 4c. County of Death Examiner IMO f Under 24 Hrs. I 9. Birthplace (State Country) Maryland 8. Date of Birth (Month, Day, 5. Social Security Number last birthday) 7. Age **Funeral** Year) Hours M 2□F 217-18-5223 Director Usual Residence of Decedent 10a State 10h. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or items 23a or 28a-f show event, I'm Madical Exeminer must be notified at MD Ellicott City Howard 1X Yes 2□No Director the 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number USA death v 21042 5330 Dorsey Hall Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ∰Yes 2 □ No If Yes, Give Year or Dates: ₩₩ T 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 A Widowed 4 Divorced White WWII Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) permit, Pages 1 and 2 should be filled will Department of Health and Mental Hygien Important: If Item 27 is marked other the any injury or other traumastic 10 Dock Worker Oil Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rachel Holt John Bosley ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Rosewood Avenue; Catonsville, MD 21228 Jack Boslev 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Mem.Garden 8/29/2008 Marriottsville, MD 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Licensee 140/490 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** HEWORKHA GE HOURS MIRA CYCANIAC disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-tran: Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician the burial Physician/Medical attending p for use as t IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) □Yes 2□No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an page 2 s has autopsy performed? certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient Oate of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation of Euneral Director: A pletely filled in by the fu 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a, Certifier 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie

State Registrar

31. Date filed (Month, Day, Year)

OLALE KA N

AUG 28

OLNFEMI 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#10b-f. perINF, G883, 9/18/08 WS
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician 6:15p M 80 26 2008 Banks Clay Lillian <u>Thelma</u> /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Rehab Center Catolis VIII

7. Age (In yrs. last birthday) | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Hours | Min. | 11 17 Summit Park Health & Rehab Center Catonsville Birthplace (State or Foreign Country) 5. Social Security Number ^{Year)} 25 **Funeral** 1 ☐ M 2**X** F MD 216-20-1769 Director Usual Residence of Decedent 10b. County N/A 10c. City, Town or Location Baltimore 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Madical Evanting on the partition once. 10a. State 1 Yes 2 2 2 100 Director Queen Chester MD Annes 10f. Zip Code 21216 10g. Citizen of What Country? 723 North Rosedale St. U.S.A. 102 Barren Ridge Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes Y☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1∐Yes 2⊠No Specify. Specify: Black ģ 3 □ Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Pharmedic Inc. Secretary 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Shorter Theodore Clay Sr. ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 102 Barren Ridge Road, Chester, Md 21619 B. Clay-Brother Edward 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 9/4/08 Arbutus, Md 22. Name and Address of Facility
March F/H West 21. Si natu of Funeral Service Licenses 21215 Baltimore, 4300 Wabash Ave, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each time.

Immediate Ceuse (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death month Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Linter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 🔲 Ectopic pregnancy Year Month Day 5 Other (specify) 9 Unknowl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>გ</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2V No 1 ☐ Yes 26. Place of Death (Check only on 25. Was case referred to medical examiner? Other: No No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Yes Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Dath 28c. Injury at Work? Natural 2 Aecident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basic of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wilkers Ave # 307 Batto. HD. 21929 MA 2531 voundo

State

31. Date filed (Month, Day, Year)

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32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 2

Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** James William Booker 2008 Jr. August 8:45 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8004 Shadow Oak Lane Pasadena Anne Arundel 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Min. 87 214-14-2352 May 26,1921 Director MD Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examination as notified at 1 ☐ Yes 2 X No Director MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8004 Shadow Oak Lane 21122 U.S.A. Funeral permit. Pages 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If then 27 is marked other then any injury or other trainments. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 □ Never Married 2 □ Married If Yes, Give Year or Dates 1 ☐Yes 2X No Specify \$ White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Diesel Mechanic Matlack Trucking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Booker Pauline Von-Stein 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. James W. Booker III/Son 1201 Watervale Court Pasadena, MD 21122 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 2008 Elkridge, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation MO0918 Services 1 2nd Avenue SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a co equence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for se a consequence off attending physician and for use as the burial-transit The law requires that the death certificate be execu Due to (or as a consequence of) P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 s performe After this certificate 2 No 1 □Yes 1 ☐Yes Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 5 Residence 6 ☐ Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Manner of Death
Natural
2 ☐ Accident 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certification: Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29c. License number Early M Drige MD Stilf Richielfry Suit 134 Pasadenamo 21/22 31. Date filed (Month) 32. gistrar's Signature Year) State Registrar

BENA, MADALINE

			For State	State	of Mai		oartment of Fertificate of			giene Reg. No./	2008	27662
	_		Registrar 1. Decedent's Name (First, Middle	, Last)			77 (1170010 0.		2. Date of Dea	ıth		3. Time of Death
	Physicia			Mada	line	Bena			August	Day 24	2008	1:15 P M
	/Medic Examin		4a. Facility Name (If not institution	, give street and n	umber)		4b. City, Town, o	r Location of Deat			County of Death	
			Greater Baltin	nore Medi	ca1	Center	Towso	n		Ва	ltimore	
	Funeral Director		5. Social Security Number 212–28–2879	6. Sex 1 □ M 2 □ F	7. Age 77	(In yrs. last birthda) Yrs.	/) If Under 1 Year Months Days	If Under 24 Hrs Hours Min.		y, Year)	Coui	place (State or Foreign ntry) Nessee
			Usual Residence of Decedent		, ,				July 2	0,19	31 16111	lessee
	how how		10a. State 10b. County			10c. City, Town or L	ocation				1	0d. Inside City Limits
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	s 23a	eral	1707 Kirkland				21222	lianania Osiaia 2 /	Canada Van av Na		ted Stat	
٥	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyliene. Important: If tiern 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a livedical Exercitival must be notified at once.	Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marri	12. Was Dec Armed F 1 \(\sum Yes	orces? 	erin U.S.	. Was Decedent of H If Yes, specify Cub. 1 □ Yes 2 🖾 No	an, Mexican, Puer	to Rican, etc.)		Black, White,	etc.
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Mary	and had is ma	_	19a. Informant's Name/Relationsh	nip (Type. Print)		19b. Mai	ling Address (Street	and Number or R	lural Route Numbe	er, City o	r Town, State, Zip	Code)
≥	and and and and and and and and and and		Ms. Patricia Be	na (Dau	ghte:	, -	17 North				, Maryla	
5	ges 1 t of H If itel		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 🗆 Removal from	n State	20b. Place of Disp cemetery, cri	oosition (Name of ematory or other plac	ce)	Date	20c. Lo	cation - City or To	own, State
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	/Medical Examiner		resulting in death)	Due to	o (or as a	consequence of):		•				
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; ;	the de	Physician/Me	1 ☐ Yes 2 🕱 No 9 ☐ Unknown	9 Uni		ime of death 5	☐ Other (specify) _					
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	ding F	ion:	27. Manner of Death 1 Natural 5 □ Pending	(Mo	e of Injury nth, Day,	Year) 28b. Time Injury	Wor	ryat k? Yes 2.∐No	28d. Describe h	now injur	y occurred	
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	To the Hospital or Attending Physician: The law requires that the death certification 24 hours after death. Within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	ledical (Examiner: On the		examination and/or	ath occurred at the ti investigation, in my					
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	8		30. Name and address of person of the state	4. Sch	WCi	M2 6	535 No	Mach	arles S	te	Suit53	-2008 Tousan U 21204
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

				partment of Health and Mental Hygiene ertificate of Death Reg. No. 2008 2766
16	Physici /Medic	_	1. Decedent's Name (First, Middle, Last) Samuel Brown	2. Date of Death Month Day Year O S 13 Time of Death 2: 20 RM.
	Examir	er	4a. Facility Name (If not institution, give street and number) GOOD SAMARITAN HOLPITAL 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)	4b. City, Town, or Location of Death Ac. County of Death County of Death Ac. County of Death Ac. County of Death BALTIMORE. If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign)
	Funeral Director		213-66-8392 1 M 2 F 54 Yrs.	Months Days Hours Min. (Month, Day, Year) June 14, 1954 Country) unk
	ie Maryland 8a-f show otified at	Director	10a. State 10b. County 10c. City, Town or Baltin	nore 1½ Yes 2 No
	th with the 23a or 2 ist be no		10e. Street and Number 115 E. Melrose Avenue	10f. Zip Code 10g. Citizen of What Country? 21212 USA
36	''natural', or items 23a or 28a-f show sidical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 □ Yes 2♥ No Specify: Specify: black
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, Maryland	d 2 shouth and N 7 is mai	ř	1 (),	oling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Loch Raven Blvd Baltimore, MD 21239
Baltimore,	Pages nent of ant: If it		1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 🖔 Other (Specify) in State	position (Name of Date 20c. Location - City or Town, State ematory or other place)
Balt	permit. Departr Imports any Inje	l k	2011	22. Name and Address of Facility tate Anatomy Board 655 W. Baltimore Street altimore, MD 21201
	Physician /Medical Examiner	er	23a. Flant 1. Enter the disease, or complications that caused the death. Do not expression of the shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. 5009 Sequentially list conditions, if any, leading to immediate	nter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Approximate Interval Between Onset and Death
8760,	cate be executed physician and the burial-transit	cal Examiner	rany, leading to immediate cause. Enter Inderlying Cause (Disease or injury that initiated events resulting in death) Last Last Lue to (or as a consequence of): acote repair of the consequence of): Due to (or as a consequence of):	, failure. with metaetasis to lung and liver.
O. Box 68	ath certifi attending for use as	Physician/Medical		B⊟Ectopic pregnancy S⊞Other (specify)
Δ.	w requires that the de been signed by the a should be detached t	þ	Part II. Other significant conditions contributing to death but not resulting in the lives failure with wage loss	underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 □ Yes 2 □ No 3 □ Probably 4 □ Onknown
Vital Records,	The law requate has been page 2 should	Completed	0 0	24a. Was an autopsy findings available prior to completion of cause of death? 1□ Yes 2□ No 1□ Yes 2□ No
Division or Vita	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification: To Be	25. Was case referred to medical examiner? 1	of 28c. Injury at Work? M 1 Yes 2 No
	To the Hospital within 24 hours of To the Funeral completely filled	Medical Co	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, de cone) Certifying Physician: To the best of my knowledge, de cone and manner stated.	rath occurred at the time, date and place, and due to the cause(s) and manner as stated. investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)
	To the He within 24 To the Fi	Me	29b. Signature and title of certifier Deep Sharma MD 10 None of Joseph (Nom 23a) (Tur	29c. License number 29d. Date signed (Month, Day, Year) RES 000 8 13 08 .
0	St	ate	30. Name aboundaries of person who completed cause of death (Item 23a) (Type Sharma Groot Soman tages) 31. Date filed (Month, Day, Year) AUG 2 8 2008	Hospital, Baltimore, MO
DH	Regist	rar	AUG 2 8 2008 Ban B. Sp.	WELT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year 12:03 PM^M Timothy Beach August 1 2008 8, 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Joseph Richey Hospice | Months | Days | Hours | Min. | Dec | Months | Days | Hours | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec | Months | Dec Baltimore Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 54 Maryland Yrs. 212-66-3068 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☑ No Baltimore Dunda1k 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21222 2702 Yorkway USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black White, etc. 1 ∐Yes 2 X If Yes, Give Year or Dates: 1 Never Married 2 Married 2 📉 No 1 ☐Yes 27 No Specify Specify: white 3 ☐ Widowed 4 X Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry disabled none 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Thomas Jefferson Beach Ola Nobia Williams unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ed Mac Sherry/friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5\\Other (Specify) in state Funeral Service Licensee 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street ∏Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HEAD/NECK MARCHANY Due to (as a consequence of) Sequentially list conditions, if one lacting to immunicate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐Yes 2 □No 1 □ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

show

Director

Funeral

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Completed

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MD

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

P.O. Box 68760,

Division of Vital Records,

Department of Health and Mental Hygiene. Important: "or items 23a or 28a-f show portant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, If a Medical Examment was burnotified at

Examiner attending physician and for use as the burial-transit certificate has been signed by the rector, page 2 should be detached filled in by the funeral director,

Physician/Medical þ Completed Certification: To 27. Manner of Death

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No

> Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28a. Date of Injury (Month, Day, Year) 5 Pending investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)

Medical

1 Natural 2 ☐ Accident

3 🗌 Suicide

4 Homicide

29b. Signature and title of certifier

AUG 28

Certifying Physician: the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

State Registrar 31. Date filed (Month, Day, Year)

2008

Registrar's Signature

To the Hospital or Attend within 24 hours after death. To the Funeral Director:

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 🛭 🗎 🖰 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3:00 a M Olivia Bynum 08-23-2008 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Charles 955⁵ Sharon Ave. La Plata If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 ☐ M 🔏 F N.C 11-1953 54 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location Md ty Yes 2 No Charles La Plata 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 14. Race - American Indian, Black, White, etc. 9555 Sharon Ave 20646 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black 1 Never Married 2 Married 1 ☐ Yes X ☐ No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Private College (1-4or 5+) + 4 Elementary/Secondary (0-12) Accounting 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last, Efula Williams David Savage 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9555 Sharon Ave.La Plata,MD 20646 20646 Charles Bynum/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Washington Nat'l. 08-30-2008Suitland, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of FacilityRonald Taylor II Funeral Hm. 21. Signature of Funeral Service Licensee 10583 Middleport Ln. White Plains, md2069 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final eas disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE:

Pnysician /Medical **Examiner**

the attending physician and hed for use as the burial-tran

signed by

has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funerel Diractor: After this certifica

The law requires that the death certificate be executed

P.O. Box 68760

Division of Vital Records,

Examiner

Physician/Medical

2

Completed

Be

Certification: To

Medical

State

Registrar

Physician

/Medical

Examiner

Funeral

Director

death with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked othar than "natural", or Items 23a or 28a-f show any injury or other traumatic avant. The Medical Examination and once.

Baltimore, Maryland 21215-0036

Completed by Funeral Director

Be

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death

4☐Pregnant at time of death 9 Unknown

3 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month

23e. Did tobacco use contribute to the cause of death?

1 Yes 2 No 3 Probably

Year Day

9 Unknown

23b. Was decedent pregnant

☐ Yes 2 ☐ No

in the past 12 months?

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

25. Was case referred to medical examiner?

Hospital: 1 Inpatient 28a. Date of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA 28b. Time of

26. Place of Death (Check only one Other: 4 Nursing Home

2 No 5☐ Residence 6 ☐ Other (Specify)

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

1 Yes 2 No 27. Manner of Deal 1- Vatural 2 Accident

5 Pending investigation Could not be determined 3 Suicide

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

24a. Was an

autopsy performed

281. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

0 31. Date filed (Month, Day, Year)

32. Registrar's Signature

AUG 2 8 2008

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Ma	ryland / Dep	artment of F rtificate of			0.0	0.0	07667
			Registrar 1. Decedent's Name (First, Middle, La	et)		Tillicate of	Dealli	2. Date of Dea	teg. No.	118	3 Time of Death
- 0	Physici		Brodie	Ear	1	Crowd	er	Month August	Day	Year 2008	0452 AM
	/Medio Examir		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, o	r Location of Dea		4c. County		
	_ X		Sinai Hospital	of Rollings		Bal	Himore				
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last birthday)				Year)	9. Birthp	place (State or Foreign
	Director		217-22-2869	K □M 2□F 8	3 Yrs.	and any		11 19			VA
	pur w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ocation				1	10d. Inside City Limits
	laryla sho	ē	MD NA		Balti						1 X]Yes 2□No
	the N 28a-f notifie	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of \	What Cou	ntrv?
Š	with a or t be r			- a			215		U.S		,
3	leath	Funeral	3908 Bareva Ro	12. Was Decedent E	ver in U.S. 13.			Specify Yes or No- erto Rican, etc.)		e - Americ	can Indian,
ر د	fter d r Iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🔀 No If Yes, Give	0			erto Rican, etc.)		ck, White,	
33.	urs a al", o Exarr	by	3 X Widowed 4 ☐ Divorced	If Yes, Give ** Year or Dates:		1 ☐ Yes 2 No	Specify:		Specif	у: В 1	ack
5-0036	72 ho natur ical	Completed	15. Decedent's E	ducation		dent's Usual Occup		orkina	16b. Kind of B	usiness/In	dustry
21.5	thin 7	g	Elementary/Secondary (0-12)	College (1-4or 5+	life.	DO NOT use retire	d)				
. 5	ed wi ygien yer th	ပ္ပ	12th grade	na	For	k Lift					el Co.
pu	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or Items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last Melvia Crowder)				_{ame (First, Middle,} e Faulkr		ne)	
<u> </u>	ould Mer narke	P		T	401. 14.77					01.1. 7	0-11
Maryland	iges 1 and 2 should be filed within 72 hours after death with the Maryla to f Health and Mental Hyglene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Brodie D. Crow	**		-		Rural Route Numbe Ba lti mo	-	-	1215
	1 and Healt em 2		20a. Method of Disposition	der-pou	20b. Place of Disp	osition (Name of	1	Date	20c. Location		
, Baltimore,	permit. Pages 1 a Department of He Important: If item any Injury or othe		1√2 Burial 2 ☐ Cremation 3 ☐		cemetery, cre	ematory or other pla	i i	/2 /00		-	
Ē	iit. P.		4 Donation 5 Other (Special 21. Signature of Fuparal Service Lice			emorial 2. Name and Addre		/2/08	Woodl	awn,	Ma
Ba	Department once		Vian ette	K. Im) Ma	rch F/H	West	, Baltin	200	ма	21215
1	W DATE		23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications hat caused t						nu [Approximate
	Physician		Immediate Cause (Final	one cause on each line	e. a						Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	c sequence of):						
	Examiner				,						
2		je l	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Discussion in Juny	b Due to (or as a	consequence of):						
X	cuted nd ransi	Examiner	that initiated events	C							
A	e exe ian aı ırial-t		resulting in death) Last	Due to (or as a	consequence of):						
8760,	ate b hysic the bi	dical		_ d							
9	ertific ling p e as	Mec	IF FEMALE:					100			
Вох 6	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1☐Live birth 2	2 ☐ Fetal death 3	⊒Ectopic pregnanc	у			ate of deliv onth	ery Day Year
P.O.	he de the a	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	ime or death 5	Other (specify)_					
σ.	that the by detac		Part II. Other significant conditions	contributing to death but	t not resulting in the u	underlying cause giv	ven in Part I.	23e. Did to	bacco use con	tribute to t	the cause of death?
ds,	w requires that s been signed b should be deta	d by	Ren	al Failne				1 □ Y	′es 2 No	3 ☐ Pro	bably 4 Onknown
Ö	w req been shoul	ete		gestive Head				24a. Was a	an 24h	Were auto	oney findings available
Re	he lar e has ige 2	Completed	Lov	gestive Hear	t Failure			- autop	rmed2	death?	opsy findings available ompletion of cause of
ta	hysician: The Is his certificate ha: I director, page 2	ပို	25. Was case referred to medical			***	26 Place of D	1 Yes eath (Check only o		1 ☐ Yes	2∐ No
5	/sicia s cert	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatien	nt 2 ER/Outpatie	nt 3 DOA Oti		Home 5 ☐ Resid		her (Sneci	(f _V)
0	g Ph er thi		27. Manner of Death	28a. Date of Injury (Month, Day	/ 28b. Time o	of 28c. Inju	ry at	28d. Describe h			-97
<u>.</u>	ath. rr: Aff	atio	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	n	rear) Injury		Yes 2 □ No				
Division or Vital Records,	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	e 28e. Place of injur building, etc.	ry - At home, farm, st (Specify)	reet, factory, office		28f. Location (S City or Tow		ber or Rur	al Route Number,
	ital o rs aft ral DI led in	Š									
	Hosp 4 hou Fune ely fil	cal	(Check only 2 Medical Exa	nysician: To the best of miner: On the basis of	examination and/or in	th occurred at the t nvestigation, in my	ime, date and pla opinion, death oc	ice, and due to the courred at the time,	cause(s) and m date and place,	anner as s , and due t	stated. to the cause(s)
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	one) 29b. Signature and title of certifier	and manner stat	ed.	29c. Licen:	se number		29d. Date signe	ed (Month	Day Year)
	N N N										
	1		30. Name and address of person who	completed sauce of de	ath (Itam 22a) (Turn		9062		Angust	21,	2008
	R		CL. 1.7	completed cause of de	Uni (nem 20d) (Type	, i iiii)	Rallina	MA 31	215		
	Sta	te	Chad J. Hans 31. Date filed (Month, Day, Year) AUG 2 8 200	. Registra	r's Signature		J4111000E	IID ZI	L/3		
	Regist		AUG 2 8 200	18 Alberta	A AND	ASL.					

DHMH 17 Rev 1/2001

Pt Warnas: Brodic Crowder

Baltimore, Maryland 21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician Month 25, 2008 4:45PM Jane C. Carey August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Sandy Spring
If Under 1 Year | If Under 24 Hrs. Brooke Grove Nursing Home Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Davs Hours Director 213-48-8721 89 July 2, 1919 Pennsylvania Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, tre Medical Experiments. 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Director 1 ☐ Yes 2 ☑ No Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 16720 Alexander Manor Drive 20905 <u>United States</u> 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No þ Specify: Specify: 3 X Widowed 4 □ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be P _Harry W. Croop Elizabeth McCloskey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
16720 Alexander Manor Drive
Silver Spring, Maryland 20905 19a. Informant's Name/Relationship (Type. Print) Edward L. Carey, Jr./ Son 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate
of Heaven Cemetery 20a. Method of Disposition 20c. Location - City or Town, State Date 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State August
aven Cemetery 29, 2008 Silver Spring, Maryland
22. Name and Address of Facility Robert A. Pumphrey Funeral Home/
Bethesda-Chevy Chase. Inc. 7557 Wisconsin Avenue
Bethesda, Maryland 20814-3501 4 □ Donation 5 □ Other (Specify) 21. Signature of Fureral Service Licensee M00335 or co will atims that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or couplications that caused the shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Div to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause (Uisease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) To the Hospital or Attending PhysIclan; The law requires that the death certificate be executed attending physician and Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Be Completed by FIBRILLATION, CONGESTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ ☐ Known 24b. Were autopsy findings available prior to completion of cause of death? HYPOTHYROLD, SQUAMOUS CELL 24a. Was an autopsy performed? Yes 2 2 No TONGUE 1 □ Yes 1 ☐Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending in 24 hours and the Funeral Director: A' 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Within 2. and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 08-25-2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SILVER SPRING, MD-20902 VE STE 209 CIEDRUIA 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 28 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician Channell Audrev August 20, 2008 12:00 a^M /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Wicomico Willards 36133 Poplar Neck Road 9. Birthplace (State or Foreign Country)
Maryland If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday **Funeral** Hours Months Days 1 ☐ M 2 🔼 F 75 12/02/1932 216 28 1985 Director Usual Residence of Decedent 10d. Inside City Limits be filed within 72 hours after death with the Maryland that Hygiene. at Hygiene do other than "natural", or items 23a or 28a-f show event, it a Modical Exprimer must be notified at event, it a Modical Exprimer must be notified at 10c. City. Town or Location 10b. County 10a. State 1 ☐ Yes 2 No Director Willards Wicomico Maryland 10g. Citizen of What Country? 10f. Zip Code 10e, Street and Number U.S.A. 36133 Poplar Neck Road 21904 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: δ White 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12th College (1-4or 5+) Montgomery Ward Bookkeeper permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If item 27 is marked other the any Injury or other traumatic event, ITEL ODGE. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Vernon Henkel Mae Franklin ဂ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21209 12 Harwick Court Victoria Jenkins / Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 08/22/2008 | Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery: 22. Name and Address of Facility 21. Signature of Funeral Service Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Due to (or as a const quence of): disease or condition resulting in death) /Medical Examiner 'OP Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: for use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 🗌 Ectopic pregnancy Month Day 5 Other (specify) P.O. 1 ed by the a detached f ☐Yes 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has 2 No certificate 1 □Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the funeral director; for the function of 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No 1 ☐ Yes ပ 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manne of Death Certification: Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier me N m n s of person who completed cause of death (Item 23a) (Type, Print) Salisbury, Maryland 21804 11 da Ziemer 100 Power Street 31. Date filed (Montin, ay, Year) 32. Registrar's Signature State AUG 2 8 2008 Regintrer

ORIGINAL

310		Registrar 1. Decedent's Name (First, Midd	fle, Last)			Cer	rtificate	OI D	eatn		2. Date of I			J Ö	3. Time o	f Death
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lica ine	-	4a. Facility Name (If not institution	on, give street an	d number)			4b. City, To			of Death		1	County o			
		4075 Serene V					Union			O.A. Idaa			arro		(0)	
al er		5. Social Security Number 216–10–0189	6. Sex 1 X M 2□	-	(In yrs. last	Vrs.	If Under 1 Months	Days	If Under Hours	Min.	8. Date of E (Month, June	Day, Year)	919	Mar	lace (State try) y Land	or Porei
	-	Usual Residence of Decedent 10a. State 10b. Count	v		10c. City, To	own or Lo	ocation							1	0d. Inside	City Limi
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	ec -	10e. Street and Number	<u> </u>	1			10f. Zip C					10g. Citi	zen of W	hat Coun	itry?	
2	Funeral Director	4075 Serene V	iew Driv	re					2179	1			U	SA		
	ner	11. Marital Status	Arme	Decedent Eved Forces?		13. \	Was Decede If Yes, specif	ent of His fy Cuban	spanic Ori	gin? (Spo n, Puerto	ecify Yes or Rican, etc.)	No-		e - Americ k, White,	an Indian, etc.	
Ė	by Fu	1 ☐ Never Married 2X Ma 3 ☐ Widowed 4 ☐ Divorce	arried 1 XI	Yes 2 ☐ No s, Give r or Dates:) 140 41	_	1 ☐ Yes 2	K) No	Specify:				Specify:	whi	te	
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	ĕ	12)			guard			<u>-</u>		<u> </u>				
18	Be	17. Father's Name (First, Middle									e (First, Midd		Sumam	e)		
	၉	C. Elmer Cyfo		41		10b Maili	ng Address ((Street =			y Seif		r Town	State 7in	Code)	
		19a. Informant's Name/Relation Sharon Cyford					Serene								21791	
SUC#	9-	20a. Method of Disposition			20b. Place	e of Dispo	osition (Name matory or oth	e of	_		Date				own, State	-
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3	Physic	ian	1. Decedent's Name (First, M.	- '								2. Date o Month		Day	Year	3. Time of Death
	/Medi		Kemani Rose 4a. Facility Name (If not institu			mher)		4h City	Town or	Location of	of Death	Augus	st 17	7 , 200		6:36 PM [™]
	Exami	ner	Southern Ma:			· ·			nton) Death					
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	and w		Usual Residence of Decedent 10a. State 10b. Cou	ntv		10c Cit	y, Town or Lo	ncation								10d. Inside City Limits
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215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or items 23a or 28a-f show int, the Medical Examiner must be notified at	d by	3 Widowed 4 Divor	1	Year or D	ates:							4.00			
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Maryland	2 sho and is ma		19a. Informant's Name/Relati			+ o 1								ity or Town,		Code)
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the M-dical Examiner must be notified at once.			Tanu	поврт			3 Sur		Koad				2073		
Baltimore,	t of H		20a. Method of Disposition 1 ☐ Burial 2 ☐ Crematic			State C	Place of Dispo emetery, crea	matory or o	ne or ther place	e)	L	Date	200	c. Location -	City or To	own, State
Ħ	artmer artant artant injury		4 □ Donation 5 📉 Othe				2	Name an	d Address	e of Eacilit						
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M	Physician		shock, or heart failure. Immediate Cause (Final disease or condition	list only on		each line.	2	110	\	10	لبيد	· +	1			Interval Between Onset and Death
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o		. To	1 ☐ Yes 2 ☑ No 27. Manner of Death		28a. Date	·	ER/Outpatier 28b. Time of		A	4 ⊔ Nu				e 6 Oth		fy)
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Ö	tal or A safter al Dire ed in by	Certification:	Tomode .		<u>L</u>	ng, etc. (Specif)						City of	Town, S	rare)		
	Hospital or Attending 24 hours after death. Funeral Director: After tely filled in by the fune		(Check only 2 Medic	ying Phys al Examin	Ician: To the	best of my kno asis of examina	wledge, deatl	n occurred a	at the tim	ne, date an pinion, dea	d place, th occur	and due to	the caus	se(s) and ma	anner as s	stated.
	To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	Medical	one) 29b. Signature and little of cert		and man	ner stated.			License					Date signe		
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		-	30. Name and address of pers	on who cor	mpleted caus	e of death (Item	23a) (Tyne	Drint)	332					011	110	
			Salem F	1-1	JABE		. 75	13 51	RRIT	775 A	2000	1 CI	inter	MD	20	735
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Registrar

08-06450 John Dittman Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

n Dittman	1	- For State	State	of Maryland	Certific	cate of l	Death			Reg. N	0	ZUU	18 2	101
Physicia			ne (First, Middle,La						Month	of Death	Yes		. Time of Deat 1200 hrs	.h
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		4a. Facility Name St. Agnes		ve street and number /			Baltimore		, .			N/A	-I (Chata as	Farsign
Funeral Director		5. Social Security 212-36-	Number 6.5	Sex 7. Ag	e (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under Hours	24Hrs. 8. Dat Min. Oct		1938	Coun	olace (State or otry) cyland	Foreign
		Usual Residence	of Decedent		10c. City, Tov	wn or Locatio	on .						I0d. Inside Cit	
Ow an		10a. State MD	1	imore			Halethor	pe					1 Yes 2	X No
e Maryland or 28a-f sh	Director	10e. Street and 1	Number Ringwood	d Drive			10f. Zip Code 21	227			Citizen of W Inited	1 Sta	tes	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any important: If reamantie event, the Medical Examiner must be notified at once.	Funeral D	11. Marital Statu 1 Never Ma	rried 2 Marri	1 1/A Yes 4	?10	If Ye	Decedent of Hises, specify Cuban	, Mexican,	n? (Specify Ye Puerto Rican, (es or No- etc.)		ite, etc.	an Indian, Blach	ck,
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21215-0036 21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medica	Be Co	John N	ne (First, Middle, La Neff Ditt	nan, Sr.				Ar	nna M.	Schae:	fer			
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite	/	4 Donation	5 Other Spe	cify:		Cemet	CTV Name and Addres	s of Facility						
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Divisior To the Hospital or Attend within 24 hours after death. To the Funeral Director:	completely filled in by the	29a. Certifier (Check only one)	1 Certifying P	hysician: To the best miner: On the basis of	of my knowled examination a	ge, death oc and/or investi	curred at the time gation, in my opin	e, date and nion, death	place, and due	to the cause time, date	se(s) and m and place,	anner as si and due to	tated. the cause(s)	
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		0	Was .				0.	C.M.E.			Augus	t 24, 200	08 	
7		30. Name an	d address of persor	who completed cause	e of death (Item	n 23a)	- Chroat Dale	imore N	ID 21201					
B11				sistant Medical E			Street, Balt	inore, iv	ID 2 1201					
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 920 PM avis Dec 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ar If Under 24 Hrs. Luiversity Maryland Medical 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1 XM 2 ☐ F 8. Date of Birth (Month, Day, Year) 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Director 217-46-4560 59 Sep. 1, 1948 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ " any injury or other traumatic event." 10a. State 10c. City, Town or Location 10d. Inside City Limits 10h. County Baltimore MD Lansdowne 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2806 Manoff Road 21227 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. 1X Yes 2 No 1968 -If Yes, Give Year or Dates: 1970 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify Specify: White þ 3 Widowed 4 Divorced 1970 Completed I 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) Coilege (1-4or 5+) Maintenance Tech Maintenance 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Leonard Decker Betty Taylor 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan Decker - Wife 2806 Manoff Road, Baltimore Highlands, MD 21227 20b. Place of Disposition (Name of cemetery, crematory or other pla 20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other (S 3 □ Removal from State 8-29-2008 Crownsville, MD 5 Other (Specify) Crownsville
22. Name and Address of Facility Ambrose Funeral Home, Inc. 21. Signatule of Funeral Service Li 1328 Sulphur Spring Rd., Arbutus, MD 21227 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** orgestive /Medical Due to (as a consequence of): Examiner arten ovenaly Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9∏Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes Completed 24a Was an has 2 No 1∐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Yes

Division or Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: neral director, To the Funeral Dir

2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2) No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 2 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and so of person who completed cause of death (Item 23a) (Type, Print) Greene Street Baltmore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State **ORIGINAL**

Registrar

Physician /Medica **Examine**

Funeral Director

		For State Registrar	State of Ma	•	partmer <i>ertifica</i> :			and M	ental Hy	giene Reg. No.	20	08	2767	L
		Decedent's Name (First, Middle, Las	t)				_		2. Date of De	eath			3. Time of Death	_
ici		James	L.		Ewing				Month Augus	Day st 2	y ! 7	Year 2008	3.46 A M	l
edic min		4a. Facility Name (If not institution, give	street and number)		4b. City,	Town, or l	ocation c	of Death		4c.	County	of Death		
		7995 Tick Neck	Road			saden	a					Arund	del	
ral or		5. Social Security Number 6. Sec 217-24-0635	ex 7.Age ⊡xxM 2□F	(In yrs. last birthda 78 Yrs	Months	Days	If Under	24 Hrs. Min.	8. Date of Bi (Month, D Nov.	rth ay, <i>Y</i> ea <i>r)</i> 04 I	929	9. Birthpl Count	ace (State or Foreig try) MD	n
8		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or	Location				<u> </u>			10	Od. Inside City Limits	3
	Director	Maryland Anne Ar	undel	Pasa	dena								1 □Yes 2 및No)
	Dire	10e. Street and Number		-	10f. Zi	p Code				10g. Cit	izen of W	hat Coun	try?	
	la	7995 Tick Ne	ck Road			211					USA			_
	Funeral	11. Marital Status	12. Was Decedent E Armed Forces?		Was Dece If Yes, spe	edent of His ecify Cubar	spanic Ori n, Mexicar	igin? (Spe n, Puerto f	cify Yes or Na Rican, etc.)	0-		e - America k, White, e		
	5	1 ☐ Never Married 2 ☒ Married 3 ☐ Widowed 4 ☐ Divorced	1	0	1 □Yes	2 ⋤ №	Specity:				Specify	. W	hite	
	oletec	15. Decedent's Ed (Specify only highest grad	de completed)	(G	ecedent's Usu live kind of we le. DO NOT u	ork done di	uring most	t of workin	g	16b. K	ind of Bu	siness/Ind	lustry	
	Completed	Elementary/Secondary (0-12)	College (1-4or 5-	+)		ntena	nce					taura	int	_
	Be	17. Father's Name (First, Middle, Last)							(First, Middle					
	ပ္	Howard Ewing						ster		Alli			0.11)	
		19a. Informant's Name/Relationship (7 Joan C. Ewing	(spouse)		ailing Addres 995 Tie								Code)	
		20a. Method of Disposition	(spouse)	20b. Place of Di	sposition (Na	me of		D	ate			City or To	wn, State	_
		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specific	Removal from State	Metro C	rematory or		/	Aug. 20	28 08	Bal	Ltimo	ore M	ary;and	
ouce.		21. Signature of Eureral Service Licen			22. Name a			ט נ	allings Pasade				e P.A.	
Н		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of	olications that caused	the death. Do not							10 21	1.2	Approximate Interval Between	
an		Immediate Cause (Final disease or condition	No		all C						20	6	Onset and Death	
al er		resulting in death)	Due to (or as a	a consequence of):										
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b Due to (or as a	a consequence of):										_
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	dical	· ·	d											
	/ledi	IF FFINALE.												
	Completed by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live birth 4 ☐ Pregnant at 9 ☐ Unknown	2 🔲 Fetal death	3 Ectopic 5 Other (s							te of delive onth	ery Day Year	
	y Ph	Part II. Other significant conditions of	ontributing to death bu	t not resulting in th	e underlying	cause give	n in Part I		23e. Did	tobacco	use cont	ribute to th	ne cause of death?	
	ed b								1	Yes 2	No No	3 ☐ Prob	ably 4 Unknow	'n
	plet				-				24a. Wa	opsy		prior to co	psy findings availab mpletion of cause of	le
-	Con								per 1 □ Yes	formed? 2 No	0	death? 1 🗆 Yes	2 🗆 No	
	Be	25. Was case referred to medical examiner?	Hospital:			Othe	p.		(Check only					_
	6	1 Yes 2 No 27, Manner of Death	28a. Date of Injur	ry 28b. Tim		28c. Injury	4 L IV		ne 5 🔀 Res 28d. Describe				y)	_
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	ertifica	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubuilding, etc	ry - At home, farm, (Specify)	street, factor	ry, office		2	28f. Location City or To	(Street a	nd Numb e)	er or Rura	al Route Number,	
	Medical Certification: To	29a. Certifying Ph (Check only one)	ysician: To the best on niner: On the basis of and manner sta	examination and/o	leath occurre or investigation	d at the tim on, in my op	ne, date a pinion, dea	nd place, ath occurr	and due to the	e cause(e, date an	s) and m	anner as s and due to	stated. the cause(s)	
	Me	29b. Signature and title of certifier Augylor	Zorbut	y and	> 25	oc. License	number	8 8		29d. Da	ate signe	d (Month,	Day, Year)	
		30. Name and address of person who	completed cause of de											_
~		Mayer Gorbaty 31. Date filed (Month, Day, Year)	22 Ronietro	2 ar's Signature	03 Hos	pital	Dr.	#312	Glen	Burn	ie,	MD 2	1061	_
Sta istr		AUG 2 8 2008			who									
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Registrar

State of Maryland / Department of Health and Mental Hygiene Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** 12:16A^M August 25, 2008 /Medical Megan Evans 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Ashley House Assisted Living Baltimore City N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 17,1921 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours Min 1 □ M 2 🖾 F 212-28-6737 87 **Director** United Kingdom Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location show d other than "natural", or items 23a or 28a-f show event, the Wedford Examinar must be notified at 1 ☐Yes 2K No Director Maryland Baltimore Dundalk 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 7 Admiral Blvd. 21222 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2√☐ No Specify Specify: <u>S</u> 3₺ Widowed 4 Divorced White Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Johns Hopkins nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Years Registered Nurse Bayview Hospital 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be fil h and Mental H Is marked ott B permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evones. Harold Jenkins Eleanor Williams ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 550 B Riviera Drive Joppa, MD Mr. Thomas J. Evans (Son) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/27/2008 Oak Lawn Cemetery Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of uneral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Myocardical Infarction 2 wks /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection
Due to (or as a consequence of): 2 Wks Sequentially list conditions, ē cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examir Physician: The law requires that the death certificate be executed burial-tranet and End Stage Dementia years Division of Vital Records, P.O. Box 68760, Physician/Medical Hypertension attending p IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ∐Yes 2XXXIII 9 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Coronary Artery Disease, Osteoarthritis, Arrhythmia, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Pacemaker, Anemia, Hypernatremia, Heart Failure 24a. Was an page 2 s autopsy 1 ☐ Yes 2 ☐ No 1 □ Yes After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 KM ther (Specify) 1 ☐ Yes 3 No Living 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred the Hospital or Attending Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a 29a. Certifier XX Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D54749 August 26, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) East Rolling Crossroads, #307 Baltimore, MD 21228 Allen Reilly, M.D. 4 31. Date filed (Month, Day, Year) AUG 2 8 2008 32. Registrar's Simature State Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** AMBUST 2 12 AZI 8 12:10PM Dorothy Teresa Friedemann /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Baltimore 4b. City, Town, or Location of Death **Examiner** owson Joseph Medical Center 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs, last birthday) **Funeral** 1 □ M 2 □ F Months Days Hours Min 219-10-2255 Director 81 Jan. 6, 1927 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, tre Medical Exemitive must be posited at Director 1 ☐ Yes 2 ☐ No MD Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8644 Oak Road 21234 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No white Specify: If Yes. Give δ 3 Widowed 4 □ Divorced Ye ar or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C&P Telephone Company Supervisor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick E. Fisher Elsie M. Ruckle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas Friedemann 3201 Safari Court; Ellicott City, MD 21042 son If Item 2 or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. 3 Removal from State Druid Ridge Cemetery |8/29/08 Pikesville, MD 21. Signature of Fu 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY ARREST disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner BREAST MASS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Dise to (or as a consequence of) sician and burial-transit Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 2 No cate has been signated by page 2 should b 3 Probably 4 Unknown 1 ☐ Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2. No 2 No 1 ☐ Yes 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 Pending investigation 1 Natural 2 Accident death. 1 ☐ Yes 2 ☐ No iours after death.
neral Director; /
filled in by the fi 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide 24 hours a Funeral I Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Laminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier completely (Check only one) and manner stated within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) tugust 25, 2008 D0067248 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TOWSON, MARYLAND 21204 31. Date filed (Month, Day, Year) 32 Registrar's Signature OSLER DRIVE State Registrar

		1	For State Registrar	tate of Ma	aryland		rtment of H tificate of D			eg. No 20	08	27677
			Decedent's Name (First, Middle, Last)		n-				Date of Deat Month		Year	3. Time of Death
	Physicia	_	Florence Julia	Gi 1	more				August	27	2008	4:45A M
	/Medic Examin		4a. Facility Name (If not institution, give street				4b. City, Town, or	Location of Death		4c. Count	y of Death	
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	Funeral		5. Social Security Number 6. Sex	7. Ag	e (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day) Dec. 24	Year)	9. Birthp	ace (State or Foreign try) and
	Director	-	218-40-1521	281	69	Yrs.			Dec. 24	, 1938	магу	rianu
	and	-	Usual Residence of Decedent 10a. State 10b. County		10c. City, 7	Town or Loc	cation				10	Od. Inside City Limits
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,	the r	Directo	Maryland Carrol 10e. Street and Number				10f. Zip Code	Ji Tugo	1	l0g. Citizen o	f What Coun	try?
:	3a or		12 N. Main St.,	Apt. 2			2	1791		U	.S.A.	
	ms 2	Funeral	11 Marital Status 12.	Was Decedent	Ever in U.S.	13. \	Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. R	ace - Americ	
9	or Ite		1 ☐ Never Married 2 ☐ Married	Armed Forces? 1		i	i Tes, specily ouba I □Yes 2 X No	Specify:	Trouri, oto.,	Spec		
21215-0036	filed within 72 hours after death with the Maryland Hygiene, Hydiene, ther than "natural", or Items 23a or 28a-f show ent, its Medical Eventiner must be multified at	d by		Year or Dates:							Wh	ite
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ä	l be f intal l ed ol	Be .	Roland C. Grimes						e Hatfi			
Maryland	hould nd Me mark matic	ဍ	19a. Informant's Name/Relationship (Type.	Print)		19b. Mailir	ng Address (Street				n, State, Zip	Code)
<u>s</u>	od 2 s Ith ar 27 is 27 is r trau		Donald A. Newton/ so			20000	Dodd Ave	e. Reho	both. D	F 1997	1	
<u>စ</u> ်	f Hea		20a. Method of Disposition		20b. Pla		sition (Name of natory or other plac		Date	20c. Location		wn, State
e E	Pages ent o nt: If i		1 Burial 2 Cremation 3 Rem 4 Donation 5 Other (Specify)	oval from State			Cemeter	1 .	72008	Denni	ngs. M	ID
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Interpartment of Health and Mental Hygiene. Incorporate: If them 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, its Medical Eventinal must be notified at once.		21. Signature of Funeral Service Licensee	0./1	60	22	2. Name and Addres					
ñ	any any any		attarine .	Har	Her		310 Churc	h St.	New Wind	sor, M	D 2177	⁷ 6
			23a. Part 1. Enter the disease, or complicat shock, or heart failure. List only one of	ons that cause	d the death.	Do not en	ter the mode of dyin	g, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
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	/Medical		resulting in death)	Due to (or as		_	V-(
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	p ±	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a conseque	nce of):						
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68760, <i>C</i>	ficate be executed i physician and s the buriat-transit	edical	d									
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Box	law requires that the death certif as been signed by the attending 2 should be detached for use as	Physician/M	in the past 12 months?	1 Live birth	2 Fetal c	leath 3	☐ Ectopic pregnanc☐ Other (specify) _	у			Month	Day Year
P.O.	the di y the ched	ysid	1 □Yes 2 ☑No 9 □ Unknown	9 Unknown								
σ.	ires that the de signed by the a I be detached f	4	Part II. Other significant conditions contri	outing to death I	but not result	ting in the u	ınderlying cause giv	en in Part I.	23e. Did to	obacco use c	ontribute to t	he cause of death?
g	puires n sign lld be	d by	HTW						1 🗆 `	Yes 2⊿No	3 Pro	bably 4 🗌 Unknown
20	w requir s been s should	Completed	Atrial Fibrilla	N					24a. Was		b. Were aut	opsy findings available ompletion of cause of
æ	The law ate has page 2 s		1110111		_				autor perfo 1 ☐ Yes	ormed?	death?	
ta	ysician: The I is certificate ha director, page		25. Was case referred to medical					26. Place of Dea	ath (Check only c	ne)		
>	Physician: r this certific ral director, I	o Be	examiner? 1 Yes 2 No	pital: 1 ☐ Inpat	tient 2 ☐ E	R/Outpatie	nt 3 DOA Oth	er: 4 \sum Nursing H	lome 5 ☐ Resi	dence 6 🖼	Other (Spec	in Do ve House
0	<u>ਦ</u> ∌ ਛ	i.	27. Manner of Death	28a. Date of Inj		28b. Time o	of 28c. Injur	y at k?	28d. Describe	how injury occ	curred	
<u>.</u>	ath. ath. nr: Af	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(111077111)	,,,,,,			Yes 2 □ No				
Division of Vital Records,	r Atte	Certification: To	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Ir building, e	njury - At hon etc. (Specify)	ne, farm, st	reet, factory, office		28f. Location (. City or To		ımber or Rui	al Route Number,
	ital o Ins aff rai Di					1			a and district		l manner = -	stated
	To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	ical	29a. Certifier 1 Certifying Physic	r: On the basis	of examinati	nedge, dea on and/or i	th occurred at the ti nvestigation, in my	me, date and plac opinion, death occ	e, and due to the urred at the time,	date and pla	ce, and due	to the cause(s)
	thin 2 the the mplet	Medical	29b. Signature and title (Nocertifie)	and manner s	stated.		29c. Licens	se number		29d. Date sig	gned (Month	, Day, Year)
	2 4 € 5		255. Signator and the piceruno	00								
	_		20 Name and address of	olated cause of	death /Item	23a\ /Timo	Print			nugust	2010	
	10		30. Name and address of person who com	OKIM S	MA	79) 3 W GAL	herty	RJ Mo	unched	(P. N	800
	Sta	te	31. Date filed (Month, Day, Year)	2. Regis	trar's Signatu	ure	AP .	1.4	, - 1100	· AFF A/L)	. 11	
	Regist		AUG 2 8 2008	Alle 13.	1 St.	30	see					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2008

27678 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 1430 PM AugusT 2008 23 Greene Augustine Sister Mary /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** AGNE OTAL BALTIMOR If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday 6 Sex **Funeral** Days Months 1 □ M 2 🙀 F 90 01 16 080-09-5237 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County r than "natural", or items 23a or 28a-f show the M. dical Examiner must be notified at Y⊟Yes 2 No Baltimore Funeral Director MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21227 701 Gun Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ♣️ No If Yes, Give 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iter any injury or other traumatic event, the M. dical Exa<u>miner</u> once. 1X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. Black Specify: þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Teacher School 12th grade 5yrs+ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be (Nancy Green Robert Green 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, 21227 701 Gun Road, Sister Richardo Maddox Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Y☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20a. Method of Disposition Ponation 5 ☐ Other (Specify) Loudon Park 8/29/08 Baltimore, Md 22. Name and Address of Facility
March F/H West 21. Sig of Funeral Service Licensee Md 21215 4300 Wabash Ave, Baltimore, Approximate Interval Between Onset and Death 23a. Part . Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition Physician n two weeks erebrougenlar disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner weeks if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year in the past 12 months? Day 5 ☐ Other (specify) 1 Yes 2 No 9 Unknown Records, P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Munknown nerebrovascular Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Asthma, autopsy performed? Yes 2 HNo 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Medical Certification: To 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death (Month, Day Year) 1 Natural 2 ☐ Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide l Scritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of codifier AUGUST 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sorth Calon 900 DALTIMORE AUG 2 8 2008 \$2. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 25, 5:20P M Frances 2008 S. Graff August /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 454 Kingwood Road Linthicum Anne Arundel Birthplace (State or Foreign Country) | If Under 1 Year | If Under 24 Hrs. | | Months Days Hours Min. | 8. Date of Birth (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Year) **Funeral** 1□M 2₹ F 72 212-32-8802 Yrs. Sept. MD Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy Injury or other traumatic event, the Medical Exprises must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 ☐ Yes 2X No **Funeral Director** MD Anne Arundel Linthicum 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21090 U.S.A. 454 Kingwood Road 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 Tyes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 □Yes 2 X No White Baltimore, Maryland 21215-0036 Specify Specify: þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Data Control Clerk BG&E 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Majka Emma Witts ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mr. John J. Graff / Son 430 Kingwood Road Linthicum MD 21090 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Maryland Vets.Cem. 2008 4 □ Donation 5 □ Other (Specify) Crownsville, MD 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen Burnie, MD 21061 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 415 **Physician** Metastatic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner and burial-tran Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown 5 Other (specify) ed by the a 23e. Did tobacco use contribute to the cause of death? funeral director, page 2 should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown 1 □ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 □ Yes 2 □ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 1 Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation i after death.

i Director: A
ed in by the fu 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide e Funerail ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 24 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title

10

State Registrar 31. Date filed (Month, Day, Year)
AUG 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

gistrar's Signature

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** Margaret Goslin <u>7;00</u> ₽^M Eva 2008 August 24. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 8238 Northview Road Baltimore Co. <u>Dundalk</u> Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1 □ M 2√ □ F 216-09-3200 100 Aug. 19,1908 Director Maryland Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examinations the multified at 1 ☐ Yes ANO Dundalk Director Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8238 Northview Road United States 21222 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Pages 1 and 2 should be filed within 72 hours after woment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or itee 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 2 🙀 No altimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. Specify: White ş 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Own Home Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Eva Bowling ည Charles R. Scoggins 19a. Informant's Name/Relationship (Type. Print) Daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 Is
any injury or other trau 8238 Northview Road Dundalk, MD Mrs. Catherine A. Goslin 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, Maryland 8/29/2008 4 ☐ Donation 5 ☐ Other (Specify) Oak Lawn Cemetery 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. 21222 Q 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Adenocarcinoma of Unknown Primary Site Physician Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: Examiner Hospital or Attending Physician: The law requires that the death certificate be execujed burial-transit Due to (or as a consequence of): P,O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 5 ☐ Other (specify) 1 ☐Yes 2 No certificate has been signed by the rector, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ፩ 1 ☐ Yes 2000No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐Yes 2 ☐ No 1 ☐Yes 2 No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1∐ Yes 2⊠ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending investigation n 24 hours after death.

le Funeral Director; Aff 1 ☐ Yes 2 ☐ No M 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🗡 Certifying Physiclan: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely within 2 the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature ap Aug. 25, 2008 D62576 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore, MD Gary R. Shapiro, M.D. Johns Hopkins Bayview Med. Ctr. 4940 Eastern Ave. 21224 31. Date filed (Month, Day, Year) 32. Registrar's Signature State makes AUG 28 2008

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		Please	State of Ma				. Ensure All lealth and Me	_		gible.	
	_	For State Registrar			•	tificate of L	Death	Re	g. No. 2	008	27681
Physicia /Medic	an	Decedent's Name (First, Middle, Last			Go	nzale	5	2. Date of Death	Day 24	200	3. Time of Death
Examin		4a. Facility Name (If not institution, give The Johns Hopkins Ho	•			4b. City, Town, or Baltimore	Location of Death	J	4c. Cou	nty of Death	1
Funeral Director		5. Social Security Number 6. Sec. 219 28 9023	7. Age	(In yrs. la 74	st birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs.	8. Date of Birth (Month, Day, 09/06/1	^{Year)} 933	9. Birth	nplace (State or Foreign ntry) a ba m a
laryland f show d at	ĺ	Usual Residence of Decedent 10a. State 10b. County M 1 1	/ ^		Town or Loc						10d. Inside City Limits 1 1 1 1 1 1 1 1 1
with the Maryland a or 28a-f show be notified at	Director	10e. Street and Number	/A			10f. Zip-Code	1225	10		of What Cou	intry?
er death wi	Funeral	606 E. Jeffrey 11. Marital Status	12. Was Decedent E	ver in U.S	. 13.		ispanic Origin? (Spec n, Mexican, Puerto Ri	ify Yes or No-	14. F	Race - Ameri	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	þ	1 Never Married 2 Married 3 Widowed 4 Moivorced	Armed Forces? 1 ☐ Yes 2 X N If Yes, Give Year or Dates:	lo	I	f Yes, specify Cuba 1 ☐ Yes 2 ੌANo	Specify:	ican, etc.)		Black, White, ecify: W	hite
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hould d Men marke	မ	19a. informant's Name/Relationship (7	Ralph Teri	гу	19b. Mailir	ng Address (Street	and Number or Rural		-	wn, State, Z	ip Code)
and 2 should eath and Mer n 27 Is marke er traumatic		Eugene Gonzales	/ Son		3032	Queensb	erry Drive	Hunti	ngtow	n, Mar	ryland 20639
Pages 1 anent of He		20a. Method of Disposition 1 ABurial 2 Cremation 3		CE	emetery, crer	osition (Name of matory or other place				on - City or T	
nit. Pa artmen ortant: Injury		4 ☐ Donation 5 ☐ Other (Specify 21. Signature) of Funeral Service Licens		Hol		11 Cemete 2. Name and Addre	se of Eacility	7/2008			Maryland
permit. Departi		Konna M Zo	muross	sh			hie Highwa	ay Bal	timore		ce, P.A. cyland 21225
Physician		23a. Part 1. Enter the disease of chmp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a State	15 t	=p116	er the mode of dyir	ng, such as cardiac or	r respiratory arm	est,		Approximate Interval Between Onset and Death
/Medical Examiner	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a	consequ a consequ	lood	Thy					27 days
sate be executed only sician and the burial-transit	g	resulting in death) Last	Due to (or as a	a consequ	ence of):						
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▼ No 9 □ Unknown	23c. If yes, outcome of the line birth and the line birth are great at an unknown	2 - Fetal	death 3 [Dectopic pregnance of the control of	у		23d.	Date of deli Month	ivery Day Year
s that t ned by	by P	Part II. Other significant conditions of	ontributing to death be	ut not resu	ulting in the o	underlying cause g	iven in Part I.		1		the cause of death?
require een sig hould I		Alzienin Divi	DIDUNG	V				1 ☐ Ye	7		obably 4 Unknown
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sician: certific	o Be	25. Was case referred to medical examiner? 1 Yes 2 A	Hospital: 1 Lispatie	nt 2 □ 1	ER/Outpatier	nt 3 DOA Oth	er: 4 ☐ Nursing Hom			Other (Spec	sifv)
ig Phy ter this ineral c	on: To	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injur (Month, Day	у	28b. Time o		y at 2	8d. Describe ho			
r Attendir ter death. rector: Af o by the fu	ertification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	. ———			M 1 eet, factory, office	Yes 2 No	8f. Location (S City or Town		umber or Ru	ural Route Number,
Hospital o	edical Ce		ysician: To the best o	examinat							
To the within 3 Comple	Med	29b. Signature and title of certifier	lund	Inc	2	29c. Licens	e number .	2	9d. Date sig	gned (Month	n, Day, Year)
1		30. Name and address of person who	completed cause of d	leath (Item	n 23a) (Type,	Print)	600 N	lorth Wol	fe St. I	Baltimo	ore, MD, 21287
Sta		31. Date filed (Month, Day, Year)	32 Registra	r's Signati	ure						

08-03627 - UNK UNK	ru2	Please Type or Print in Black Indel	ent of Health and Mental H			8 2768
Juan Carlos Physician	n/	Registrar 1. Decedent's Name (First, Middle,Last)	ate of Death	2. Date of Death	. No.	3. Time of Death
Medical Examin	ier	Juan Carlos Guzman 4a. Facility Name (if not institution, give street and number) 6300 Sligo Park Way	4b. City, Town, or Location of Death	May 12, 200	4c. County of Death Prince George	
Funeral Director		5. Social Security Number unk 6. Sex 17. Age (In yrs. last bin $1 \underline{X} $ M 2 F 36		8. Date of Birth		inplace (State or unk untry)
Haryland 28a-f show any 1 at once.	or	Usual Residence of Decedent 10a. State	Hyattsville			10d. Inside City Limits 1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho	I Director	10e. Street and Number 6300 Sligo Parkway	10f. Zip Code 20783		g. Citizen of What Cour	- GIIIC
s after rral",	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced of Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a.	13. Was Decedent of Hispanic Origin? (State of Yes, specify Cuban, Mexican, Puerto of Yes, Specify: M6 1 Yes 2 No specify: M6 Decedent's Usual Occupation (Give kind of Vertical Occupation)	Rican, etc.)	White, etc. Specify: W	can Indian, Black, white Industry unk
036 ithin 72 hou sne. r than "nat	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) unk unk	during most of working life. DO NOT use reti	red)		
:1215-0 Id be filed w fental Hygic narked othe event, the A	B	Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type, Print) 19	UTIK 18.Mother's Name			unk
e, MD 2 1 and 2 shoul Health and M item 27 is m	٥	O . C . M . E . 1 20a. Method of Disposition 20b. Place	b. Mailing Address (Street and Number or I 11 Penn Street Balti of Disposition (Name of cemetery,	more, MD	-	
Baltimore, MD 21215-0036 bernit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than njury or other traumatic event, the Medica		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 X Other Specify: in, state 21 Signal re of Fun Service License Ronald S Director	22 Name and Address of Facility State Anatomy Boars	1 655 W	Raltimore	Stroot
Physician /Medical Sxaminer		23a Part I. Enterthe disease, or complications that caused the death. Do n failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	Baltimore, MD 2120 ot enter the mode of dying, such as cardiac of)1		Approximate Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated				
and and	ᇹ	events resulting in death) Last Due to (or as a consequence of): d. UNPENDED AMENDED				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should be detached for use as the burial	ysician/Medic	past 12 months	2 Fetal death 3 Ectopic pregn.	ancy	23d. Date of deliver Month	y Day Year
s, P.O. B ires that the de is signed by the	d by Phy	Part II. Other significant conditions contributing to death but not resulting	ng in the underlying cause given in Part I.		pacco use contribute to 2 ✓ No 3 Pro	
of Vital Records, g. Physician: The law require ther this certificate has been si neral director, page 2 should be	Completed			24a. Was a autops perform	prior to death?	utopsy findings available completion of cause of es 2 No
Vital Rec hysician: The I this certificate I	To Be (Tes 2 No	26.Place of Death (Check Outpatient 3 DOA Other,4 Nursi		Residence 6 🗸 Othe	r: Scene
Division of Value of Attending Phyras after death. al Director: After the in by the funeral	Certification:	1 Natural 5 Pending 2 Accident Investigation May 12, 2008	Time of Injury UND: 11 hrs 28c. Injury at Work? 1 Yes 2 ✓ No	Subject shot	ow injury occurred , stabbed and cut	
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the 1		Suicide Could not be determined (Specify) Park/Recreation 29a. Certifier 1 Continue Revision To the best of my knowledge de		or Town, St 6300 Sligo Par	ate) rk Way , Hyattsville,	
To the II within 24 To the F complete	Medical	one) 2 Medical Examiner:On the basis of examination and/or and manner stated. 29b. Signature and title of certifier	investigation, in my opinion, death occurred 29c. License number		and place, and due to the 29d. Date signed (Mo	ne cause(s)
		30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Per	O.C.M.E. an Street, Baltimore, MD 21201		May 13, 2008	
Sta Registr	at e rar		Spelle			
OCME 2006	ot.	Of	RIGINAL		OoviE	

AVON SEAN GARRISON Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-06413 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1- For State Reg. No Registrar 2. Date of Death 1 Decedent's Name (First, Middle Last) Physician/ Month Day August 22, 2008 0302 hrs Medical Examiner Tavon Sean Garrison 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore Johns Hopkins Hospital 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Country) MD **Funeral** Days Hours Months 12-06-1979 Director 28 215-94-6953 $_{1}$ X_M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Baltimore 23a or 28a-f show notified at once. MD 10g. Citizen of What Country? Director 10f. Zip Code 10e. Street and Number 21213 2932 Edison Hwy 14 Race - American Indian, Black 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Funeral 12. Was Decedent Ever in U.S. White, etc. be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 XNever Married 2 Married hours after death 2 X No Yes 5 Specify: Black 1 Yes 2 X No specify: f Yes, Give Year or Dates: 4 Divorced Widowed ≥ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) permit. Pages I and 2 should be filed within 72 I Department of Health and Mental Hygiene. Important: If item 27 is marked other than "r injury or other traumatic event, the Medical E Unemployed 21215-0036 12th 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Phillip Johnson Phyllis Garrison (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address MD 2 MD 21213 Park Heights Ave 20c. Location - City of Town, State Victoria Johnson/Sister Date 20b. Place of Disposition (Name of cemetery 20a, Method of Disposition Baltimore, crematory or other place) 08-30-08 1 X Burial 2 Cremation 3 Removal from State Baltimore, MD Mt. Zion Cemetery Donation 5 Other Specify: 22. Name and Address of Facility Ronald Taylor II Funeral Hm 11. Sonature of Funeral Service Licenses 108 W. North Ave Baltimore, MD 21201 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and Physician failure. List only one cause on each line Death /Medical a. Multiple Gunshot Wounds Immediate Cause (Final disease Examine or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Uncerlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and - transit The law requires that the death certificate be executed Physician/Medical AMENDED g physician a UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE Year 23b. Was decedent pregnant in the Month Day 3 Ectopic pregnancy tive birth Fetal death past 12 months? Pregnant at time of death Other (Specify ned by the atter detached for u Yes 2 No 9 Unknown q Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 1 Yes 2 No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available Records, 24a. Was an page 2 should prior to completion of cause of autopsy has b performed? death? 1 Yes ✓ Yes 2 No certificate 26.Place of Death (Check only one) the Hospital or Attending Physician: 25. Was case referred to medica Division of Vital Be Other₂ examiner? Hospital: Residence 6 Other Inpatient 2 V ER/Outpatient 3 Nursing Home 5 DOA this 1 V Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) FOUND: 28c. Injury at Work? 28b. Time of Injury 27. Manner of Death After Certification: Subject shot FOUND: Yes 2 V No Natural 5 Pending within 24 hours after death. To the Funeral Director: completely filled in by the Aug 22, 2008 0220 hrs 2 Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. Could not be or Town, State) 2400 Block East Lanvale Avenue, Baltimore, Md. Suicide (Specify) Sidewalk 4 V Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 1

Registra DHMH 17 Rev 1/2001 **OCME 2006**

Medical

State

29b. Signature and title of certifier

Carol Allan, MD 31. Date filed (Month, Day, Year)

32. Registrar's Signature

and manner stated

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 22, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST 25 Day 2008 ar 5:40 AM ROSEMARIE GOLBERG 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE RANDALLSTOWN NORTHWEST HOSPITAL CENTER | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | Min. | 06/119/119/32 Birthplace (State or Foreign
Country) 5. Social Security Number 7. Age (In yrs. last birthday) 1□M 2**X**F UNKNOWN GERMANY 76 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No BALTIMORE BALTIMORE MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21208 16 OLD COURT ROAD USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 1 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 1/1 If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married WHITE 1 □Yes 2 No 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE ASSISTANT REAL ESTATE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SALLINGER SAUL GERDA LINK 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MICHAEL KOHLMEYER-HYMAN/NEPHEW 16 IDLEWOOD ROAD, WHITE PLAINS, NY 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State CHEVRA AHAVAS CHESED 08/27/2008 RANDALLSTOWN, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. 21. Signatur of Funeral Service Licensee 22. Name and Address of Facility 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part I/ Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. SEPSIS Immediale Cause (Final disease or condition resulting in death) Due to (or as a consequence of): PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day Month Year 4 Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ATRIAL FIBRILLATION; COAGULOPATHY; ACUTE RENAL 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕅 Unknown FAILURE; STATUS POST CARDIORESPIRATORY ARREST; 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? LUNG MASS; ANEMIA 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 XInpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

Physician /Medical Examiner Examine

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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7 is marked other than "natural", or items 23a or 28a-f shor traumatic event, the "Modical Experience in ust be notified at

filed within Hygiene.

d 2 should be filed w th and Mental Hygies 7 is marked other th

permit. Pages 1 and 2 s Department of Health ar Important; If item 27 is any injury or other trau once.

Maryland 21215-0036

Baltimore,

the burial-tran physician

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of Vital Records,

Division

certificate

Physician/Medical

Ď Completed

Be

Certification: To

2 Accident

4 Homicide

(Check only one)

29b. Signature and title of certifier

3 Suicide

29a. Certifier

after death.

I Director: After this d in by the funeral d or Attending completely filled in by within 24 hours a Hospital

Medical

State

MD ORLANDO B. CONÂNAN,

6 ☐ Could not be

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

D19502

1 ☐ Yes 2 ☐ No

10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year)

AUGUST 25, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

NORTHWEST HOSPITAL CENTER

5401 OLD COURT ROAD, RANDALLSTOWN, MD

Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month Day Year **Physician** 2:50 Vernisha E. Harris 8 22 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Harford Gardens Baltimore
FUnder 1 Year | If Under 24 Hrs. N/A Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 1 □ M 2 X F 76 6-10-1932 N.C. 239-48-5434 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10h County 10a. State r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☑Yes 2 ☐ No Director MD N/A Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 by Funeral 2609 Cecil Avenue death Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 Is marked other than "natural", or ite Iry or other traumatic event, the Medical Examine. 1 Yes 2 Y If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry Completed 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Max Ruben Clothing Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Seamstress 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams Samuel Vernisha Strong 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 Is any Injury or other trau Balto, MD 21215 e 20c. Location - City or Town, State Linwood E. Harris-Husband 2609 Cecil Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 8-28-2008 Owings Mills, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March East F/H 1101 E. North Avenue Balto, MD 21202 0 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on schline. Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month Year in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No the 9□Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 | Yes 2 | No 3 | Probably V Unknown been s 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes No 24a. Was an has autopsy No No 1∐ Yes 3 No certificate 26. Place of Death (Check only one) 25. Was case referred to medical Be Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Medical Certification: To this 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28b. Time of completely filled in by the funeral 27. Magner of Death Injury at Work? within 24 hours after death. To the Funeral Director: After Injury Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3□ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the 29d. Date signed (Month, Day, Year)

3

DHMH 17 Rev 1/2001

Registrat

3 Det filed (Month, Day, Year) AUG 2 8

29b. Signature and title of certifier

2. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ORIGINAL

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2008 1:45 a Craig August 28 S. Hawbecker 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 11036 Harding Road Howard Laurel f Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) MAR 22 1952 Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1 XM 2 ☐ F 56 Yrs Pennsylvania 214-58-3537 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐Yes 2X No MD Howard Laurel 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 10635 White Rock Court 20723 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 K No Specify. Specify: White 3 Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Type Setter Printing 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Germaine Lambert Edwin D. Hawbecker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 11036 Harding Road, Laurel, MD Heather Mayhew - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/28/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Williams 22. Name and Address of Facility Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final resulting in death) Due to (or as a cons Cange Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a conse Due to (or as a consequence IF FEMALE: If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Year Month Day 5 Other (specify) ☐Yes 2 ☐No 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f st Examiner must be notified

permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a any injury or other traumatic event, the Mental

Director

Funeral

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Completed

Be

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Examine

Physician/Medical

Completed by

Be

Certification: To

Medical

/Medical

Hospital or Attending Physician; The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, physician the burlal attending p as ed by the a detached f signed by this After within 24 hours Iter death.

To the Funeral Director. A completely filled in by the fu death.

		<i>V</i>					performed?	death?	2 No
25. Was case referred to medical		1=			26. Place	of Death (Check only one)		
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inp	oatient 2 🗆	ER/Outpatient	3 🗆 🛭	OOA Other: 4 Nur	sing Home	e 5 ☐ Residence	6 🛣 Other (Specia	ex-wife's
27. Manner of Death 1 Natural 5 ☐ Pending 2 ☐ Accident investiga	, ,	Injury Day, Year)	28b. Time of Injury	М	28c. Injury at Work? 1 ☐ Yes 2 ☐ N		d. Describe how injur	ry occurred	
3 Suicide 6 Could no 4 Homicide determin	t be ed 28e. Place of building	Injury - At ho , etc. (Specify	ome, farm, street	, facto	ry, office	28	f. Location (Street an City or Town, State	nd Number or Rure e)	al Route Number,
29a. Certifier Certifying	Physician: To the b	est of my know	wledge, death o	ccurre	ed at the time, date and	d place, ar	nd due to the cause(s	and manner as	stated.

10

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 3:25 AM AUG. 24 Jean Wanda Haffner 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner AGNE Social Security Number Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Min. 1□M 2 F Months Yrs 064-05-1905 93 Director 12/12/1914 Germany Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 715 Maiden Choice Lane HV210 21228 United States Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Specify. 3 Widowed 4 □ Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Hygiene. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administration Dairy Production 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ferdinand Krueger ဥ Alvina Timer 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dr. William H.J. Haffner (Son) 11616 Danville Drive, Rockville MD 20852 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2
Cremation 3 ☐ Removal from State Baltimore, Maryland Bayview Crematory 08/27/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Hubbard Funeral Home, Inc. Mark T. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, of camplications that ca shock, or heart failure. List only one cause on ea and cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition cardiomyo **Physician** year s disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any harmy to improve the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of) physician the burial attending p as IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f P.O. 9 Unknown 9 Unknown cate has been signed in page 2 should be det 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown certificate has been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performe Vital 2 No Yes 2 ☐ No Physiclan: director, 25. Was case referred to medical 26. Place of Death (Check only one) Medical Certification: To Be examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Division or After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation or Attending 1 Matural Iniury 1 ☐ Yes 2 ☐ No 2 Accident death. within 24 hours after death

To the Funeral Director: ,
completely filled in by the f 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital 1 🖟 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) M.O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UD Baltimore a110 900 cater

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 28

32. Registrar's Signature

AUC

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 2008 **Physician** ARRIS en /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner BALTIMOR N/A Ltimore 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) ocial Security Number **Funeral** Months Days 1 X M 2 □ F 56 05/23/1952 212 58 6943 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a, State 1 ☐ Yes 2 ☑ No notifled Funeral Director Baltimore Anne Arundel Maryland 28a-f 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 3 ury or other thaumatic event, the Medical Examiner must be or ury or other traumatic event, the Medical Examiner must be or U.S.A. 21225 423 W. 5th Avenue 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Viet Nam Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Baltimore, Maryland 21215-0036 Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Construction 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Frederick Harris Doris Runge 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 423 W. 5th Avenue Baltimore, Maryland 21225 Barbara Harris / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages
Department of H
Important: If ite
any injury or of 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland 4 □ Donation 5 □ Other (Specify) 08/25/2008 MD State Veteran Cem. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part : Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Heart disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transi ang / Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, cate has been signed by the attending physician page 2 should be detached for use as the burial Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1☐Yes 2☐No 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? death?
1 ☐ Yes 2 No this certificate 2 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Medical Certification: To Be Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient nours after death.

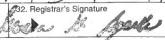
neral Director: After this
filled in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 2 Accident Injury 5 ☐ Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide within 24 hours a 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

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State Registrar AUG 2 8 2008

30. Name and addr

ss of person who con



pleted cause of death (Item 23a) (Type, Print)

ONOR

State of Maryland / Department of Health and Mental Hygiene

1 - State Registrar amend #30 Per DVR G882 8/28/08 III Amend Amend Reg. No. Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8 **Physician** Nellie 20Ŏ8 Ε. Hoban 8:20 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Frostburg Village Frostburg Allegany | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Nov 30, 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🛱 F 220-16-5635 Maryland Director 101 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.

Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Experiment must be rectified at once. Director 1 ☐ Yes 2X No MD **Allegany** Frostburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? One Kaylor Circle 21532 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: white þ Specify: 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 10 0 nursing aide healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Metty Elizabeth Holler ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Pinto/daughter 47 S. Grant Street Frostburg, MD 21532 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town. State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4M Donation 5 ☐ Other (Specify) 21. Sio lature of Funeral S ryice Licensee Ronal d S Wade State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ACUTE CEREBROUASCUVAR ACUIDENT disease or condition resulting in death) /Medical Examiner ARTERIAL CEREBRAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) The law requires that the death certificate be executed s certificate has been signed by the attending physician and irector, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.O. ☐Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ CORDINARY ANTERY 1 Yes 2 No 3 Probably 4 Punknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: ours after death.

eral Director: After this certific filled in by the funeral director, I 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide within 24 hours a

To the Funeral C

completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 026907 AUGUST 15, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harjit S. Sidhu Cumberland Maryland 21502 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 2 8 2008 Registrar

	1	For State Registrar	State of Maryland / Dep Cea	artment of Health and rtificate of Death		No. 2008 2103				
Physicia /Medica	in	Decedent's Name (First, Middle, Last) Amelia		Hill	The state of the s	Day 2008 20:07				
Examine	er	4a. Facility Name (If not institution, give s The Johns Hopkins Ho 5. Social Security Number 6. Sex	spital	4b. City, Town, or Location of D Baltimore City If Under 1 Year If Under 24	Hrs. 8. Date of Birth	9. Birthplace (State or Fore				
Funeral Director			M 2 💢 F 58 Yrs.		OCT 26,	1949				
and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examiner must be notified at		10a. State 10b. County MD	10c. City, Town or L Baltimor	e		1 Yes 2				
23a or 26 st be not	ō∣	10e. Street and Number 201 S. Madeira St		10f. Zip-Code 21231		Ac. County of Death Ac. County of Death				
Department of Health and Mental Hygiene. Important If Item 273a or 28a-f show Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 Nover Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 \(\text{Yes} \) 2 \(\text{Y} \) No	Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 ☐ Yes 2 No Specify:	? (Specify Yes or No- uerto Rican, etc.)	Black, White, etc.				
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th and Me 27 is mark traumatic	욘	19a. Informant's Name/Relationship (Ty) Johns Hopkins Hos		ling Address (Street and Number) N. Wolfe Stree	or Rural Route Number, o t Baltimore	City or Town, State, Zip Code) , MD 21287				
ent of Heal ht: If Item 2 y or other		20a. Method of Disposition 1 Burial 2 Cremation 3 F 4 Donation 5 Other Specify)	errioval from State	position (Name of ematory or other place)	Date 20	Oc. Location - City or Town, State				
Departm Importar any Injur once,		21. Signature Francisco Nonald S.	//// see	Saltimore, MD 2	1201					
ysician Medical kaminer	<u>.</u>	shock or heart failure. List only or Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	Due to (or as a consequence of):			Onset and Deat				
hysician and the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of): Due to (or as a consequence of): d.							
iding p use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 X No 9 ☐ Unknown		B		Month Day Yea				
been signed by the atter should be detached for	٥	Part II. Other significant conditions co	ntributing to death but not resulting in th	e underlying cause given in Part I.	23e. Did tob	1/				
has ge 2	Completed				24a. Was an autopsy perform	prior to completion of caused? death?				
certifica lirector,	To Be C	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpat	Other		nce 6 C Other (Specify)				
er death. rector: After by the fune	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident 3 Suicide 6 Could not be 4 Homicide determined	28a. Date of Injury (Month, Day Year) 28b. Place of injury - At home, farm, building, etc. (Specify)	y Work? M 1 ☐ Yes 2 ☐ N	0	reet and Number or Rural Route Number				
Funeral Funeral	edical Ce	29a. Certifier (check only one) Certifying Physics	ysician: To the best of my knowledge, deliner: On the basis of examination and/o and manner stated.	eath occurred at the time, date and r investigation, in my opinion, deat	I place, and due to the ca h occurred at the time, d	ause(s) and manner as stated. ate and place, and due to the cause(s)				
within 2 To the comple	Med	29b. Signature and title of certifier Bisratalia	hand, Medical Doc			od. Date signed (Month, Day, Year) TUGVST 18, 2008				
 St	ate	30. Name and address of person who Bisrat Abraha 31. Date filed (Month, Day, Year)	completed cause of death (Item 23a) (Ty M The Johns Ho 32 Registrar's Signature	pe, Print) oking Hospital, (600 North Wol	fe St, Baltimore, MD, 2				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend 10a, 10c, 10e-f, perFH G882 8/28/08 TF
State of Maryland / Department of Health and Mental Hygiene 27692

			= State Registrar	Cer	rtificate of Death	Reg. N	lo.
Ħ	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Curtis M. Hoston			2. Date of Death Month D	Oay Year 3. Time of Death 10:30 pw
3 	Examin		4a. Facility Name (II not institution, give street and num A 4910 Crenshaw Ave	pt c	4b. City, Town, or Location of Dea Baltimore		c. County of Death
	Funeral Director		579-38-6218	7. Age (In yrs. last birthday) 8 4 Yrs.	If Under 1 Year If Under 24 Hrs Months Days Hours Min		9. Birthplace (State or Foreign
	Maryland f show	tor	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or Low	BAltimore		10d. Inside City Limits 1 ½ Yes 2 □ No
	with the N a or 28a- be notifi	Director	10e. Street and Number 4910 Crenshav	v Ave. # C	10f. Zip Code 21204	10g. (Citizen of What Country?
0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinat result is notified at	d by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12 Was Deceding of Status 14 Was Deceding of Status 15 Was Deceding of Status 16 Was Deceding of Status 17 Was Deceding of Status 18 Was Deceding of Status 18 Was Deceding of Status 19 Was Deceding of Status 19 Was Deceding of Status 19 Was Deceding of Status 10 Was Deceding of Status 11 Was Deceding of Status 12 Was Deceding of Status 12 Was Deceding of Status 13 Was Deceding of Status 14 Was Deceding of Status 15 Was Deceding of Status 16 Was Deceding of Status 17 Was Deceding of Status 18 Was Deceding of Status 18 Was Deceding of Status 19 Wa	2 □ No ve ates:	Was Decedent of Hispanic Origin? (If Yes, specify Cuban, Mexican, Pue 1 ☐ Yes 2 ☑ No Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - American Indian, Black, White, etc. SpecifyBlack Kind of Business/Industry
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Baitimore, Maryland	permit. Pages 1 and 2 should Department of Health and Mer Important: If item 27 is marke any injury or other traumatic once.		19a. Informant's Name/Relationship (Type. Print) 11 YSSES HOSTON SON 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee	State 1601 20b. Place of Dispo cemetery, crem Harmony	2. Name and Address of Facility O	ashington Date 2008 02-2008 Dald Taylo	
	ocertificate be executed redical physician and miliam physician and near as the burlal-transit	ical Examiner	Sequentially list conditions, if any, leading to immediate cause. E. ter underlying Cause (Disease or injury that initiated events	ach line.	ter the mode of dying, such as cardi	ac or respiratory arrest,	Approximate Interval Between Onset and Death WWWMS
P.O. Box 68		by Physician/Medical	in the nest 12 months?	nant at time of death 5	☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delivery Month Day Year
ds, r.	e law requires that the death has been signed by the atte ie 2 should be detached for u	d by Ph	Part II. Other significant conditions contributing to d	eath but not resulting in the u	inderlying cause given in Part I.		co use contribute to the cause of death?
al Recol	 The law requires that the death ficate has been signed by the atter r, page 2 should be detached for r 	Completed				24a. Was an autopsy performed 1 □Yes 2	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
Division of Vital Records,	To the Hospital or Attending Physician: The I within 24 hours after dea h. To the Funeral Director After this certificate ha completely filled in by the funeral director, page	Certification: To Be	27. Manner of Death 1 Natural 5 Pending (Mon investigation	Inpatient 2 ER/Outpatie of Injury nth, Day, Year) ER/Outpatie 28b. Time of Injury	nt 3 DOA Other: 4 Nursing	eath (Check only one) Home 5 A Residence 28d. Describe how in	
Divis	tal or Atters of all of incertor ed in by the	Certific	4 ☐ Homicide determined build	e of Injury - At home, farm, sti ling, etc. <i>(Specify)</i>	·	City or Town, Si	
p	he Hospi in 24 hour he Funer pletely fille	Medical ((Check only 2 Medical Examiner: On the	basis of examination and/or it		curred at the time, date	and place, and due to the cause(s)
b	To t with To tl	Ž	29b. Signature and title of certifier 30. Name and address of person who completed cau And the state of the	7-6	29c. License number 5830	3 29d.	Date signed (Month, Day, Year)
			30. Name and address of person who completed cau. AHUN J- CHAWES N	se of death (Item 23a) (Type,	Print Churles ST	TONSON M	2
	Sta	ate	31. Date filed (Month, Day, Year)	Registrar's Signature	de la		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 26, 2008 (LUQUST 10hael ones /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore General Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Months Days 53 Yrs. 13-64-5735 -1955 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Examination must be notified at once. 1 Yes 2 □ No more Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 203 12 nin Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. Was Decedent Ever in U.S. Armed Forcet ? 1 Yes 2 No If Yes, Give Year or Dates: 11. Marital Status 1 Never Married 2 Married 2 No ltimore, Maryland 21215-0036 1 ☐ Yes Specify Specify: ac þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) DISABled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 1 ichael DOOTA ou a JONES ပ 19b. Mailing Address (Street and Number or Rural Route Number, Sity or Town, State, Zip Code) Informant's Name/Relationship (Type. Print) BUITU . Mo RAT WORTH Jones mother 040 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 08 30 08 Orraine Funeral Home 21. Signature of Funeral Service Licenses 22. Name and Address of Facility B2170, NO 21207 tow le Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): C Examiner HOVA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician for use as the burial IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Year Month Day in the past 12 months? 5 ☐ Other (specify) 2 □ No □Yes After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner?
1 √Yes 2 □ No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 Maryland

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 2

32 Registrar's Signature

2008

8

Amend #21, perFD G882 8/28/08 TT State of Maryland / Department of Health and Mental Hygiene 27694 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ANG 2 Jos 1709 AM ALKSON 25 **Physician** -ABIAN /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner ISACTI MORE tospi MAZ If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** 39 1**∄**M 2□F Yrs. 29-1969 214-08-4197 and Tary Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after deeth with the Maryland 10b. County 10c. City, Town or Location 10a State f Health and Mental Hygiene. Item 27 Is markad other than "neturel", or Itema 23a or 28a-1 ehow other traumatic event, It a Modical Examinan mant be inclined at 1 Tes 2 No Baltimore Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1538 21202 110 Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 215 If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗓 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Coflege (1-4or 5+) Elementary/Secondary (0-12) Moving 12 18. Mother's Name (First, Middle, Maiden Sumane) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked othe eny injury or other traumatic avent 17. Father's Name (First, Middle, Last) Be Jackson lterbert ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a_Informant's Name/Relationship (Type, Print) 20b. Place of Disposition (Name of cemetery, crematory or other place) st. Balto. brother 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Greenmoust Cremetur 4 □ Donation 5 □ Other (Specify) 21. Signature of Funcia Service Licenses M00162 Per Dyn Name and Address I Facility Carlos 1015 ante X. Jemill Approximate Interval Between Onset and Death 23a. Pan. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory sock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to for as a consequence of Examiner be executed the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): been signed by the attending physicien should be detached for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Cenal 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA After this 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred completely filled in by the funeral 27. Manner of Death 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after deat To the Funeral Director: 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) PAUL PLACE BACTIVIOLE AN ZIWE 501 ひく 05 3 Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 **AUG 28** Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Kenneth Johnson 25, 5;55A [™] 2008 August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 907 Sunnybrook Drive Anne Arundel Glen Burnie 8. Date of Birth (Month, Day, Year)
Dec. 27,1924 If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 1 M 2 □ F 7. Age (In yrs. last birthday, **Funeral** 212-20-6397 83 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exp.: Inc. outsit to retified in 1 ☐ Yes 2 X No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21060 U.S.A. 907 Sunnybrook Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Specify: Š 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4 Westinghouse Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Earl Johnson Ruth V. Plain ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 907 Sunnybrook Drive Glen Burnie, MD 21060 Mrs. Gisela Johnson/ Wife Date 27. 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Aug. 2 2008 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) GLen Burnie, MD Glen Haven Mem. Park 22. Name and Address of Facility Singleton Funeral & Cremation 21. Signature of Funeral Service Licensee arele Services 1 2nd Avenue SW Glen Burnie, MD 21061 Virile 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Coronary Artery disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner bronic Kidne Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine be executed burial-transit Diabetes Helitus and Due to (or as a consequence of): Box 68760, attending physician for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate in 24 hours after death. Funeral Director: After this certificate has been signed by the attending physis IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Yea in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached for P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Ś 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 □Yes 2 No 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral C 29a, Certifier 1 🔂 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D0065548 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1 8096 DEdwin Raynor Blud Pasadena, MD 21122 MD Colodonato 31. Date filed (Month, Day, Year) 32. gistrar's Signature State AUG 28 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygieney For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 5:10 PM 2008 Samuel Edward Jones /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 435 Radom Road Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday **Funeral** Days Min. Hours 1 X M 2 □ F Sept 14, 1953 Maryland 212-56-8257 54 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County ar than "natural", or items 23a or 28a-f show the Medical Exemitiva must be notified at 1√TYes 2 □ No Director Baltimore MD the 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number within 72 hours after death with 21219 USA 435 Radom Road Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No black Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed unk Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) e filed within 7 all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) laborer traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be fil.
Department of Health and Mental H
Important: If Item 27 is marked oth
any injury or other traumatic event 17. Father's Name (First, Middle, Last) Be Annie Pearl Malone Samuel E. Jones ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Tammi Jones/daughter 1256 Halstead Road Baltimore, MD 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 S. Wade Rona I Prector 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immedia ause (Final disease or c dition resulting in death) **Physician** Pancreatic /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 🗆 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No Ö the ped 9 Unknown signed by the ٣. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 M Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No After this certifical funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) July 1500V Hospital: Other: 4 Nursing Home 5 Residence 6 Cher (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA HOSPICI Certification; To 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending 1 🔀 Natural 5 Pending investigation To the rusping within 24 hours aiter death.

To the Funeral Director Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Momicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) REISTERS TOWN MD 21136 25 MAIN STREET 60cran 31. Date filed (Month, Day, Year) Registrar's Signature State AUG 28

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 20 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 25 amont /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner SAINT AGNES BALTIMOPE HOSPITAT If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 6. Sex **Funeral** Mary I and 17 M 2 F 3 5 Yrs. 86-0246 Director 10d. Inside City Limits 10b. County 10c. City, Town or Location Baltimore 1 Yes 2 No NIA Dary land Director 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code United Staks 21215 by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) I ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black If Yes, Give Year or Dates: 3 Widowed 4 Divorced 16b. Kind of Business/Industry Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) -abover 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Undrews Johnnie ပ injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health an Important: If item 27 Is any injury or other trauonce. Baltimore MO 21215 Barbara 20b. Place of Disposition (Name of cemetery, crematory or other place)

Mount Zion Cem 20a. Method of Disposition .30,268 1 Surial 2 □ Cremation 3 □ Removal from State 5 Other (Specify) 21. Signature of Funeral Service Licensee MO 21229 70 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) YEARS THYMOMA **Physician** METASTATIC /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? -Amon Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 nknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide time certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature a 25 2008

State Registrar 30. Name and addre

31. Date yed (Month, Day,

AUG 28

Caton

Ballimore

person who completed cause of death (Item 23a) (Type, Print)

State of Maryland / Department of Health and Mental Hygiene 0 0 8

Certificate of Death Reg. No. 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** 26, 2008 1:45 P.M. August Bong /Medical 4b. City, Town, or Locetion of Deeth 4c. County of Death 4a Fecility Name (If not institution, give street end number) Examiner Anne Arundel Crofton Crofton Convalescent Center 8. Date of Birth (Month, Day, Yeer) Aug. 25, 1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Hours 1⊠M 2□ F Yrs. 1919 Korea 89 218-96-6708 Director Usuel Residence of Decedent 10d. Inside City Limits with the Meryland 10c. City, Town or Location 10a. State 10b. County Show r than "natural", or items 23a or 28a-1 sho the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Glen Burnie Maryland Anne Arundel Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number United States 21061 116 Lincoln Drive Funeral permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s any Injury or other traumatic event, the Medical Examiner must 13. Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Never Married 2 12 Married 1 ☐ Yes 2 🖾 No Specify: Baltimore, Maryland 21215-0020 Asian þ 3 Widowed 4 Divorced Year or Detes Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Self Employed Business Owner 18. Mother's Name (First, Middle, Maiden Surname) 17. Fether's Neme (First, Middle, Last) Be Gil Cho Nak Kim ဥ 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 116 Lincoln Dr., Glen Burnie, Maryland 21061 Jeong Kim / Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Aug. 2008 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Davidsonville, MD Lakemont Mem. Gardens 4 Denation 5 Other (Specify) 22. Name and Address of Facility 21. Signal yre of Experal Serv Kirkley-Ruddick Funeral Home, P.A. 21061 421 Crain Hwy., S.E., Glen Burnie, MD 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Heart Failure Examiner ettending physician end for use es the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760 Physician/Medical tour as a consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes δ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Was an autopsy performed? Completed 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4₺ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 ☐ Yes 2 ☒ No 28e. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred filled in by the funeral 28b. Time of 27. Menner of Death 1 ☑Natural 5 Pending investigation 2 □ No 1 ☐ Yes i or Attendin efter death. Director: Aft 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 4 Homicide Mospitai 24 hours e Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29a. Certifier Medical To the I within 2 To the I 29d. Date signed (Month, Day, Yeer) 29c. License number 29b. Signature and title of certifler August 27, 2008 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Sang Cheol Doh, M.D., 1600 Crain Hwy., S, Glen Burnie, Maryland 21061 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

ORIGINAL

DHMH 16 Rev 6/95

2008 27699

Michael Harry Kost	1- F	or State	Sta	ate of ivia	ryianu i	Cert	ificate of	Death				Reg. N	0		3. Time of Death
Physician/	1.	<u>ristrar</u> Decedent's Name									Mo Aux	nth Day gust 25, 20	Yea		1438 hrs
M Examine	1	Michael !	Kostin	sky				1h City To	wn or l	ocation of D	Death	gust 20, 20	4c. County of	of Death	
	4a	. Facility Name (if		n, give street a	ind number)		\	Baltimı		0000001					
		Saint Agnes			17 An	o (In ure In	st birthday)	If Under		If Under 2	4Hrs. 8. D	ate of Birth (M	M/DD/YYYY	g. Birt	hplace (State or
Funeral		Social Security N		6. Se x	_ ,	56		Months	_	Hours:	Min. C	8/17/1	952	Foreigi Cou	untry) MD
Director	2	13–60 – 53	75	1 XM 2	F		Yrs	•							
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w any	1)a. State MD	Howa					.cott	City	Y					1 Yes 2 XNo
-f sho	با ق	עוני) De. Street and Nu						10f. Zip	Code			10g.	Citizen of W		
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5-06 wi	5	7. Father's Name							1	Kath	ryn K	irkwoo	E		
be fill richard land land land land land land land lan	8	Leon Kos	stinsk	y 	rint)		19b. Maili	ng Address	S (Stree	at a a d Niumi	or or Pural	Route Number	er. City or To	wn, Stat	e, Zip Code)
221 thould Me is ma	₽┌	Mrs. El	ame/Relation	Kostins	sky (W	ife)	3916	Paul	Mil	.l Roa	d, El	TICOLL	CICY	, 110	21012
ME alth a alth a rm 27	-	20a. Method of Di				20h	Place of Disp	osition (Na	me of ce	metery,	Da				or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.		1 X Burial 2		on 3 Re	moval from	State Me	crematory or adowri	gde M	emor	ial	08/2	9/200B	ETKI	riage	e, Maryland
Page ment trant:	١,	Donation 21. Signature of F	5 Other	Specify:	^	i	22	. Name and	Addres	s of Facility	Hub	hard F	imera.	1 Ho	me, Inc.
Balti permit. Departu Import injury		12.0	11 (1 1 .	-lon	-		4107	Wilk	kens A	venue	. Balt	imore.	, Mai	ryland 21229
25/2004/2004	+	23a. Part I. Enter	the disease,	or complicatio	ns that caus	ed the deat	h. Do not ente	r the mode	of dying	, such as c	ardiac or res	spiratory arres	t, shock, or	neart	Between Onset and
'ysician Medical		failure. List o	only one cau	se on each in			cardi								Death
∈xaminer	-	Immediate Cause or condition resu	e (Final disea iting in death) Due to	o (or as a co	nsequence	of):								
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Box 6876(e death certificate the attending phy ed for use as the t	/sic	1 Yes 2	No 9		Unknow	'n								a material state	e to the cause of death?
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ion of Vital Records, P.O. Box 6876C tending Physician: The law requires that the death certificate or: After this certificate has been signed by the attending physite functal director, page 2 should be detached for use as the b	. To	1 ✓ Yes 27. Manner of D	2 No eath		28a. Date of	f Injury	28b. Time	of Injury		njury at Wo		28d. Describe	how injury o	ccurred	
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Division tal or Attendians after death.	cat	2 Accider		Investigation Could not be	28e. Place	of Injury - A	At home, farm,	street, fact	ory, offic	ce building,	etc. 2	28f. Location (or Town, \$	Street and N State)	lumber o	or Rural Route Number, City
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± € ₽ ₽ .				ng Physician:	To the best	of my knov	vledge, death	occurred at	the time	e, date and	place, and o	tue to the cau the time, date	se(s) and mand place,	anner as and due	to the cause(s)
To the Hos within 24 h To the Fun completely	Medical	one) 2	✓ Medica	Examiner: Or an	the basis of manner st	f examination	on and/or inve	stigation, ii	i my opii	IIOII, death	00001100	, 0010			(Month, Day, Year)
S. William	ĕ	29b. Signature		ertifier						ense numb	CI		Augus		
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• Ø		30. Name and	address of p	erson who com	pleted caus	e of death (item 23a) 111 Penn S	Stroot D	altimo	re MD 2	1201				
Ψ		Ling Li,		sistant Med	90				artiiiiD	IC, IVID Z					
Pagi	stat		Month Day,	7008	32. Re	egistrar's Si	nature	W.							

Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last, Month **Physician** /Medical 4c. County of Death Name (If not institution give Examiner andalistow toce n Year If Under 24 Hrs. 8. Date of Birth (Month Day, Mar 12, 9 Birthnlace (State or Foreign 7. Age (In yrs, last birthday, al Security Numbe **Funeral** Months Days 1933 1 □ M 2 😾 F 75 Maryland 212-32-3544 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a, State "natural", or items 23a or 28a-f show edical Examiner must be notified at 1 ☐ Yes 2√☐ No Director Baltimore Randallstown 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21133 USA 9109 Liberty Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important; If Item 27 is marked other than "nature!" --- any Injury or other transmitted. 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: white Saltimore, Maryland 21215-0036 þ 3 Widowed 4 □ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) restaurants server unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be Eva Hummer ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 734 Glenwood Avenue Baltimore, MD Margaret Hummer/daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 NOther (Specify) in state 21. Signature of Funeral Service Licensee State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 21201 Approximate Interval Between Onset and Death Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part1. Immediate Cause (Final disease or condition resulting in death) Physician Dementia /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to or as a consequence of) Examiner The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical as the for use 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Year in the past 12 months's 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 ☐ Other (specify) the detached 9☐Unknown 9 | Unknown þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 1 🗌 Yes 3 ☐ Probably 4 ☐Unknown plnods Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s prior to death? autopsy certificate has 1□ Yes Physician: 25. Was case referred to medical examiner? 26. Place of Death Check onl one funeral director, Be Other: 4 Nersing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🗌 Yes 211110 1 🔲 Inpatient 2 ER/Outpatient 3□ DOA Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner eath After Hospital or Attending 1 2 atural 5 Pending investigation 124 hours after death.

The Funeral Director: All pletely filled in by the fun M 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely the 29c. License number 29d. Date signed (Month, Day, Year) 29t Signature an 2 and Pagistrar's Signature 31. Date filed (Month, Day, Yea State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 1 1 1 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2008 /Medical County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give stre Examiner hmore owson 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Date of Birth (Month, Day, Funeral Days Hours 1 M 2 F Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygeiner. In Department of Health and Mental Hygeiner in Internation of Health and Mental Hygeiner in Internation of Items 23a or 28e-f show Important; Items 71 is marked other than "natural", or items 23a or 28e-f show any injury or other traumatic event, the Medical Examination count be notified at 1 Yes 2 No Director Baltimore 10g. Citizen of What Country? 10e. Street and Number 21212 Tranhoe Funeral . Was Decedent Ever in U.S Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race · American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married 3altimore, Maryland 21215-0036 Specify: Black 1 ☐Yes 2 No Specify ģ 3 ₩idowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Assistan 12 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last) Be ၉ boodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Jame/Relationship (Type. Print) 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician CEREBROVASCULAR ACCIDENT disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner Due to for as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi hed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 ☐ Yes 2 🕱 No 5 ☐ Other (specify) 9 Unknown After this certificate has been signed by funeral director, page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 👿 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 \(\to \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) \(\text{HOSPICE} \) 1 ☐ Yes 2 👿 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 X Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) 29d Pate signed (Month, Day Year) and manner stated. 29c. License number 29b. Signature and title of certification

State

CARRIE LIPSCOMB

State Registrar 2300 DULANEY VALLEY RD.

32. Registrar's Sic lature

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ERNESTINE WRIGHT

8 2008

Month, Day,

08-06499 Rose Marie Law

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 27702

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Physicia dical Exami	an/	1. Decedent's Name (First, Middle, Last) Rose Marie Law	Mo	nte of Death	Year	3. Time of Death
aicai Exami	ner		Location of Death	gust 25, 2008 4c. Co.	unty of Death	
		University of Maryland Medical Center Baltimore			N/A	,
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yea Months Day	e Hours Min		Cou	nplace (State or Foreign ntry)
Director		218 22 3272 1 M 2XF 80 Yrs.		09/10/192	/ Per	nsylvania
any		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
and show nce.	5	Maryland Carroll Hampstead				1 Yes 2 X No
Maryli r 28a-f	Director	10e. Street and Number 10f. Zip Code	07/		of What Count	try?
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Interest is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at once.		1310	074 spanic Origin? (Specify			an Indian, Black,
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5-00 led will Hygier I other		17. Father's Name (First, Middle, Last)	18 Mother's Name (Firs			
21215-(uld be filed wental Hyg	o Be	Michael Graczilla 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre		nica Bagii Route Number City o		Zip Code)
AD 2 shou and N and N 27 is n matic	ř	Jane M. Law / Daughter 4510 Willow		: Hampstead	d, Mary	land 21074
re, M 1 and 2 7 Health fitem 2 er traum		20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of or crematory or other place)	emetery, Dat	e 20c. Loca	ation - City or	Town, State
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Baltimore, permit. Pages 1 ar Department of Hee Important: If ite		1 1004 51	^{ss of Facility} Gonce hie Highway			
Physician		236 Part I. Enter the dispesse, or complications that caused the death. Do not enter the mode of dying				Approximate Interval Between Onset and
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. Pulmonary thromboembulus co	mplicating	atrial		Death
xaminer		or condition resulting in death) Due to (or as a consequence of): fibrillation				
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Fineral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - trans		IF FEMALE: 23b. Was decedent pregnant in the 2count 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3	Ectopic pregnancy		ate of delivery onth E	/ Day Year
Box 687 ne death certific the attending p	Physician/	4 Pregnant at time of death 5 Other (Specify)				
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Division Spital or Attent hours after death meral Director:	Cert	4 Homicide determined (Specify) 29a. Certifier 4 Continue Physician, To the best of my knowledge, death occurred at the time.				
To the Hos within 24 h To the Fur completely	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion	date and place, and due on, death occurred at the	to the cause(s) and net time, date and place,	nanner as state , and due to th	ed. ne cause(s)
To with To com	Med	and manner stated.	nse number			nth, Day, Year)
		After Bransy (UND) O.C.	C.M.E.	Augus	st 26, 2008	
		30. Name and address of person who completed cause of death (Item 23a) Molices Proceed MAD Assistant Medical Examiner 111 Penn Street	Baltimore, MD 212	201		
	tate	Loo & Control Control				
Regis		The state of the s				

State Registrar

AUG 28

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) AUGUST 1:00 PM MILLER 4b. City, Town, or Location of Death
BALT / MORE 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4RBOR HOSPI If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 9-7-1948 9. Birthplace Country) (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 217-52-3329 1**X** M 2□ F 59 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 □Yes 21 No MD ANNE ARUNDEL BALTIMORE 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 532 Alden St 21225 USA Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married 1 ☐Yes 2 No Specify: Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) construction engineer construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Dorothy J. Schafer Martin J. Miller Jr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 532 Alden St. Baltimore MD 21225 Elizabeth A. Miller / spouse 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a Method of Disposition 1 X Burjat 2 ☐ Cremation 3 ☐ Removal from State 8/30/2008 Brookly Park, Holy Cross Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Kirkley Ruddick Funeral Home PA 21. Signature of Funeral Service License M01364 421 Crain Hwy SE Glen Burnie MD 21061 23a. Part 1. Entur the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PNEUMONIA disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day 5 Other (specify) □Yes 2□No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PAILURI 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 \(\subseteq No 1 🗌 Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide

Physician /Medical Examiner

Physician /Medical

Examiner

Director

Funeral

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Be Completed

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Funeral

Director

item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at

Pages 1 and 2 should be filed within 72 hours after unent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or iten

Hygiene.

permit. Pages 1 Department of the Important: If ite any injury or of

Baltimore, Maryland 21215-0036

death with

burial-trai physician the burial attending p been signed by the should be detached funeral director, within 24 hours after death

To the Funeral Director:
completely filled in by the

Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be Completed by Physician/Medical Be

Examiner Certification: To

25. Was case referred to medical examiner?

BALTIMORE

29b. Signatute and title of certifier

29a. Certifier

PHYSICIAN

and manner stated.

29c. License number 000

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) AUGUST 27 2008

Name and address of person who completed cause of death (Item 23a) (Type, Print)

ANA BEAN 3001 SOUTH HAN HANDUER 3001

State Registrar

Medical

31. Date filed (Month, Day, Year) 2008



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Nancy P. Mellendick August 25, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Greater Baltimore Medical Center Towson Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 1 □ M 2 🗙 F Days Hours 214-66-6581 Sep. Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Baltimore Halethorpe 1 □Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4416 Maple Avenue 21227 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No 3 🗆 Widowed 4 🗆 Divorced Specify: White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles J. Mellendick Virginia Ann Henderson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia A. Mellendick - Mother 301 Tiree Court Unit 304, Abingdon, MD 21009 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Atlantic Crematory 8-27-2008 Glen Burnie, MD 32. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 F.fl.1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. mmediate Cause (Final dult respiratory disease or condition resulting in death) Stream Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): MINARY Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 menths? 3 Ectopic pregnancy Month Day ☐Yes 2 No 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an autopsy performed 1 □Yes 2 □No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1. Natural 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

To the Hospital or Attending Physician: The law requires that the death certificate be exwithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician completely filled in by the funeral director, page 2 should he disached for use as the burion

Physician

/Medical

Examiner

Funeral

Director

ar than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Id be filed within 72 hours after i ental Hygiene.

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Physician

/Medical Examiner

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Be Completed

Certification: To

ical

Directo

Completed by

State Registrar

DHMH 17 Rev 1/2001

GOSME

31. Date filed (Month, Day, Year)

Charles

St. Suite 550 Towson

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 9:20 AM **Physician** 08 lanaer larence /Medical 4c. County of Death 4b. City Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Rosedale Baltimore Franklin Square 9. Birthplace (State or Foreign Country)
Baltimore MD If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 5. Social Security Number Sex 1 M 2 □ F 7. Age (In yrs. last birthday) Year) Funeral Days Hours Min 92Yrs. 160-14-7217 Director Usual Residence of Decedent 10d. Inside City Limits 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Even in error ust be putified at once. 1 ☐ Yes 2 No **Funeral Director** Baltimore 10g. Citizen of What Country? 10e. Street and Number 21030 USA 12. Was Decedent Ever in U.S. Armed Forces?
1 IA Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Manger Clarence / LL Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: white Completed by 3 X Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) Glive kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wain 12 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be Manger Hoffmann Hdam ဂ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3 Flanders Ridge Ct. CockeySVIIE MD o MD 21030 lip Manger- Jon Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) mid Ridge Concetery 8/22/08 BALTIMORE MD 21. Signature of Funeral Service Licenses Evans Funeral Chapel - Clemation Services Bothille) rock 23a. Part 1. Enter the disease of complications that caused the fleath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Jist only one cause on each line. Interval Between Onset and Death 5 - 30 min-Immediate Cause (Fin Due to (or as a consequence of): **Physician** disease or condition resulting in death) /Medical Examiner unknown SChemic Cardiomyopathy
Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) been signed by the should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Certification: To Be Completed by Effusions, Acute on Chronic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Pleuval After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 1 No 1 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation vithin 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 08-19-2008 M-D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 709 EASTERN BWD, MD-21221. WASERM 31. Date filed (Month, Day, Year) AUG 2 8 2008 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

			For State	State of Ma	ryland /		artment <i>rtificate</i>			and Me			2008	277	07
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-	/Medic Examin		4a. Facility Name (If not institution, gir		р 1100	0 2 11.3		Town, or	Location				. County of Death		
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	Funeral		5. Social Security Number 6.	Sex 7. Age	(In yrs. last I	-	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8 Min.	B. Date of Birt (Month, Da Septembe	th y, Year,	9. Birthp	place (State on htry)	r Foreign
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lan	alid be Aenta rked ric ev	To B	Howard McCorn	mick							Marti				
Maryland	s mal	-	19a. Informant's Name/Relationship	(Type. Print)	I .								or Town, State, Zip		1.5
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Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ira M. dical Even in the multiple of once.		21. Signature of Funeral Service Live	mark	M0130)5 R	obert A 57 Wis	nd Addres N. Pun consi	iphrey n Avei	Funera	al Home/ ethesda,	Beth Mar	nesda-Chevy yland 20814	Chase, -3501	Inc.
			23a. Part 1. Enter the disease, or cor shock or heart failure. List only	mplications that caused	the death. D	o not en	ter the mod	de of dyir	ng, such a	s cardiac or	respiratory a	ırrest,		Approximatinterval Be Onset and	te tween
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	St Regist	ate rar	31. Date filed (Month, Day, Year)		rar's Signatur	Local	60								

Certificate of Death

For State Registrar

Box 68760. attending physician P.O. I Division of Vital Records, After 1

1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Vear Homer H. McIntyre, Jr. **Physician** Р^М 2008 9:45 August /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Rockville Nursing Home Rockville Montgomery 8. Date of Birth Feb. 22, 9. Birthplace (State or Foreign Ohio 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Year 1923 **Funeral** Hours Min. 85 Months Days 1 XM 2 □ F 486-28-9090 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "naturar", or items 23a or 28a-f show any Injury or other traumatic event, Ith "M-dical Examinar must be notified at any Injury or other traumatic event, Ith "M-dical Examinar must be notified at any Injury or other traumatic event, Ith "M-dical Examinar must be notified at any Injury or other traumatic event, Ith "M-dical Examinar must be notified at any Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other traumatic event, Ith "M-dical Examinar must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be nother must be not always and Injury or other must be not always and Injury or other must be not always and Injury or other must be 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location Director 1 X Yes 2 □ No Maryland Rockville Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20850 303 Adclare Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? 1 ☑X/es 2 ☐ No Black, White, etc. 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: WWII 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 2 No White Specify Specify: <u>ک</u> 3 ☐ Widowed 4 🖾 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Federal Government Comptroller 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Homer H. McIntyre, Sr. Sybil Edwards ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Trudy Plumpton/Daughter 304 N. Fayette Street #607 Shippensburg, PA 17257 20b. Place of Disposition (Name of cemetery, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State 20a. Method of Disposition August 27, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland 2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue Rockville, Maryland 20850 21. Signature of Funeral Service Licenses M01498 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Renal Failure disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Renal Tumor Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 Yes 2 🗌 No 2 Accident 24 hours after death e Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🔲 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D0019785 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Fauke Westphal, M.D. 1201 Seven Locks Road #202, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) AUG 2 8 2008 32. Registrar's Signature State 194A Registrar

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			Registrar				tilicate of	Deali		Re 2. Date of Deat	g. No. 2	108	3 Time of Death
	Physicia	an	1. Decedent's Name (First, Middle	. Last)		11	ENZE			Month	Day	Year 2008	7:00 AM
and Age	/Medic	_	4a. Facility Name (If not institution,	give etmot and ru	imbor)	MOE	4b. City, Town,	or Location		AUGUST	1	y of Death	7.001
	Examin	er	8237 N. Bou	_				imore				imore	
. (6	Francisco .			6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Yea	r If Unde		B. Date of Birth	1	9. Birthp	lace (State or Foreign
	Funeral Director		214-20-3000	1□M 2□F	97	Yrs.	Months Days	s Hours	Min.	(Month, Day, /21/191	1	West	Virginia
•	All and All		Usual Residence of Decedent									· .	
	how at		10a. State 10b. County		10c, City	y, Town or Lo	cation					1	0d. Inside City Limits
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	or 28	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen of		try?
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	72 hours after death with the Maryland natural", or items 23a or 28a-f show dical Examiner must be notified at	Funeral	11. Marital Status	Armed F		.S. 13. \	Was Decedent of f Yes, specify Co	f Hispanic O Jban, Mexic	origin? (Spec an, Puerto R	ity Yes or No- ican, etc.)		ack, White,	
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Mary	2 should I and Men is marke aumatic		19a. Informant's Name/Relations	nip (Type. Print)		19b. Mailir	ng Address (Stre	et and Num	ber or Rural	Route Number	, City or Tow	n, State, Zip	Code)
Ĕ	nd 2 allth a 27 is r tra		Mrs. Imagene Ba	ughman/Da	aughter	8237	N. Bou	ndary	Road	Baltimo	re, Ma	rylan	d 21222
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Division	for A after of Direct	Certification:	4 ☐ Homicide detern	iined bui	lding, etc. (Speci	ify)	, , , , , , , , , , , , , , , , , , , ,			City or Ton	n, State)		
	Hospital or Attending 24 hours after death. Funeral Director: After stely filled in by the fune		29a. Certifier 1 Certifying	ng Physician: To t	he best of my kn	owledge, dea	th occurred at th	e time, date	and place, a	and due to the	cause(s) and	manner as	stated.
	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical one)	Examiner: On the	basis of examin anner stated.	ation and/or i	nvestigation, in r	ny opinion, o	death occurre	ed at the time,	date and plac	ce, and due	to the cause(s)
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	5		30. Name and address of per or	who completed ca	use of death (Ite	m 23a) (Type					, , , , , ,		2000
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	Regist	rar	AUG 2	8 2008	1861451 .	AS PS	19-90						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MACDOUGALL Day **Physician** MURTLE AUGUSTAN 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A HARBOR HOSPITAL CENTER itimore 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 8. Date of Birth (Month, Day, Year) 5. Social Security Number Min. **Funeral** Months Days Hours 1 ☐ M 2 🏋 F 77 Maryland Director 218 24 6659 03/31/1931 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show Pages 1 and 2 should be filed within 72 hours after death with the Maryla ment of Heatih and Mental Hygiene.
ant: If Item 27 is marked other than "natural", or Items 23a or 28a-f shov ury or other traumatic event, the Medical Examiner must be notified at ury or other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No N/A Baltimore Director Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21230 U.S.A. 201 Warren Avenue Apt. 302 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 Specify Specify: White þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Meadow Air Freshner Factory Worker 8th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Addison Painter Mabel Hunter 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Emmett, Idaho 83617 Phyllis Vernon / Daughter 1304 Vista Drive 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 08/29/2008 Baltimore, Maryland Department of Important: If any injury or once. Bayview Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Gonce Funeral Service, P.A. 21. Signature of Funeral Service Licensee 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final MYDCARDIAL INFARC Physician LITE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner MENINGIT Some flatly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner HEART The law requires that the death certificate be executed use as the burial-transi ONGESTIVE and Due to (or as a consequence of): P.O. Box 68760. IF FFMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, Completed by 1 Yes 2 No 3 Probably HYPERTENSION 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No BACTEREMIA 24a. Was an autopsy 2 No or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2**7**No 2 ER/Outpatient 3 DOA 1 🔲 Yes **Inpatient** After thi funeral 27. Mann of Death Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: Injury 5 Pending within 24 hours after co...
To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Resident

Registrar

State

BALTIMORE

CENTR

91998

mo

3001

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 2 8 2008

HARBOR

32. Registrar's Signature

131100

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 8 9 Stan Cu 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Examiner N/A Bathmore University Mayland Medical Center 0+ Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1 🖺 M 2 🗆 F 39 Maryland Director 213 06 9996 01/05/1969 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits r 28a-f show notified at 10a. State 10b. County 1 TYPes 2 □ No Baltimore Director N/AMaryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 7 is marked other than "natural", or Items 23a or traumatic event, the Medical Examiner must be it U.S.A. 21225 4102 - 8th Street 14 Bace - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 ★Yes 2 No If Yes, Give Year or Dates: 1 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 Specify: 2 White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Takoma Park 1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Police Officer Police Department 12th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Stanley Junior McLean Frances Helen Henderson ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health at Important: If Item 27 is any injury or other trau Baltimore, Maryland 21225 4102 - 8th Street Stanley McLean / Father 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville, Maryland MD State Veteran Cem, 08/25/2008 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Gonce Funeral Service, P.A. 4001 Ritchie Highway Baltimore, Maryland 21225 23a. Part1. Enter the disease of complications that caused the death. 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Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 hor To the Fune completely fi (Check only

Division or Vital Records, P.O. Box 68760,

State Registrar

Sheinfold Date filed (Month, Day, Year) 8 AUU Z

29b. Signature and title of certifier

S

Bathmore, MD

29c. License number

29d. Date signed (Month, Day, Year)

08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

and manner stated.

32. Registrar's Signature

Amend 20a-c,22, perFD G882 8/29/08 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Physician August 17, 2008 1:53 PM M Bernardo Matute /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3501 St. Paul Street #340 Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. May 27, 1916 5. Social Security Number unk 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1**∑**M 2□F Equador 92 Yrs. Director Usual Residence of Decedent the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or items 23a or 28a-f ehov the Medical Exproper must be notified at 1 Yes 2 No MD Directo Baltimore 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 3501 St. Paul Street #340 21202 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 X Never Married 2 ☐ Marned Baltimore, Maryland 21215-0036 T☐ Yes 2☐ No Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clerk steamship other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be and Mental Tomas Matute Maria Becerra 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 00979 Maria M. Matute/niece 7043 Rd 187 #515B Playa Dorava Condos, Carolina, PR 20a. Method of Disposition
1 ☐ Burial 2 ★ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: if eny injury or once. 4 □Donation 5 ₩ Other (Specify) in state Bayview Crematory 8/29/2008 Baltimore, MD S22 Name and Address of Facility Harie P. Close Funeral Service, P.A. 21. Signature Baltimore, MD 2120121206- 5126 Belair Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death PARKINSON Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 Other (specify) ☐Yes 2☐No been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by AIMSL 4 Winknown 3 Probably 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 Table 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home ၉ No 1 Tes 5 Residence 6 Other (Specify) this : After thi 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury al Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide To the Hospitai Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signelti (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MENUE 6 HE16H PARK ٥

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year,

AUG 2 8 2008

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death Reg. No.

Physician /Medical Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any hjury or other traumatic event, the Medical Examination of any high page.

Physician

Baltimore, Maryland 21215-0036

/Medical Examiner

within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

Marshoull & 1968 1.55pm

	State Registrar 1. Decedent's Name (First, Middle, Last)		Certificate of	Deaui	2. Date of Death	, No.	Year	3. Time of Death	
ı	Jeffrey Marshall				August 1	9, 20	08	1:55 PM M	
Į.	4a. Facility Name (If not institution, give street and number	·)	4b. City, Town,	or Location of Dea		4c. Count			
	Joseph Richey Hospice		Balt	more					
4	5. Social Security Number 6. Sex 7. A	ge (In yrs. last birt	hday) If Under 1 Yea	If Under 24 Hrs	8. Date of Birth	(nar)	9. Birtl	nplace (State or Foreig	
-	213-62-7430	53	Yrs. Months Day	Hours Min	8. Date of Birth (Month, Day, Sept 8,	1954	Mai	ryland	
-	10a. State 10b. County	10c. City, Town	or Location					10d. Inside City Limits	
	MD	Ba	ltimore					1 ☐ Yes 2 ☐ No	
-	10e. Street and Number		10f. Zip Code		100	g. Citizen of	What Co	untry?	
	828 N. Eutaw Street			21201	S	US.		rican Indian,	
	11. Marital Status 1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced 12. Was Decedent Armed Forces 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:	?] No	**	Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, etc.) □ Yes					
	15. Decedent's Education (Specify only highest grade completed)		(Give kind of work dor	Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry					
	Elementary/Secondary (0-12) unk College (1-4or unk	5+)		18 Mother's No	ame (First, Middle, Ma	aiden Surna	me)		
	17. Father's Name (First, Middle, Last) Willie Marshall			Mamie	Williams				
	19a. Informant's Name/Relationship (Type. Print) Claymond Williams/uncle		Mailing Address (Stre 606 Loch R		Baltimore	e, MD	212	39	
Î	20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 ☒ Donation 5 □ Other (Specify)	cemeter	Disposition (Name of ry, crematory or other p	lace)	Date 2	Oc. Location	- City or	Town, State	
	21. Signature of Foneral Source Licensee Ronald S. Wade Vir	1980r	22. Name and Add State Ana	tomaz Roaz	d 655 W. 1	Baltin	nore	Street	
	resulting in death) Due to (or a	ATDS as a consequence of						Interval Between Onset and Death	
	cause. Enter Underlying Cause (Disease or injury that initiated events c	is a consequence	•						
1		2 Fetal death at time of death	3 ☐ Ectopic pregn: 5 ☐ Other (specify			1	Date of de	llivery Day Year	
	Part II. Other significant conditions contributing to death LIVER FAILURE	but not resulting in	n the underlying cause	given in Part I.		acco use co s 2 🗆 No		o the cause of death?	
			-		24a. Was an autopsy perform 1 Yes 2	,	prior to death?	utopsy findings availal completion of cause c s 2 □No	
	25. Was case referred to medical examiner?				eath (Check only one)			
	1 ☐ Yes 2 Z No Hospital: 1 ☐ Inpa		Itpatient 3 100A		Home 5 ☐ Reside		Other (Spe	ecify) HOSPIC	
	Accident investigation		Injury \	njury at Vork? □Yes 2□No	28d. Describe ho				
	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of I building,	njury - At home, fa etc. <i>(Specify)</i>	arm, street, factory, offi	e	28f. Location (Str City or Town	eet and Nu , State)	mber or F	tural Route Number,	
1	29a. Certifier (Check only one) Certifying Physician: To the beside and manner	of examination a	e, death occurred at th nd/or investigation, in r	e time, date and play ny opinion, death o	ace, and due to the ca ccurred at the time, da	ause(s) and ate and plac	manner a e, and du	as stated. e to the cause(s)	
	29b. Signature and title of certifier	1	29c. Lic	ense number	29	ed. Date sig	ned (Mon	th, Day, Year)	
	1/1 and distance		175	92/3		2/10	1/01	2	
	30. Name and address of person who completed cause of	f death (Item 23a)	(Type, Print) 38 No E. S	82/7	7,	2.502	2/01	B 212001	

Registrar

AUG 2 8 2008

State of Maryland / Department of Health and Mental Hygiene Kevin Bruce Moody 2008 27714 1- For State Certificate of Death Reg. No. Registrar 3. Time of Death 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Month August 6, 2008 1930 hrs al Examiner Kevin Bruce Moody 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Baltimore 123 East Cross Street 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or unk 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 5. Social Security Number unk 6. Sex **Funeral** Days Months Hours Min Dec 1, 1956 Country) Director 51 X_{M} Yrs 2 F Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location Į, 10a. State 10b County X Yes 2 No MD Baltimore or items 23a or 28a-f show must be notified at once. the Maryland Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 21230 USA 123 E. Criss Street 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status unk If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? death Never Married No unk Yes Yes 2 X No specify: Specify: black hours after Widowed Divorced If Yes, Give Year the Medical Examiner "natural" þ 16a, Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry unk 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene.
ant: If item 27 is marked other than " Baltimore, MD 21215-0036 unk unk Com 18.Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) O.C.M.E. 111 Penn Street Baltimore, MD 21201 tment of Health ar rtant: If item 27 y or other traums 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) Burial 2 Cremation 3 Removal from State Donation 5 X Other Specify: im state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street permit. Director Baltimore, ΜĎ 2120 Approximate Interval Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart hysician Between Onset and ilure. List only one cause on each line Medical Death a. Atherosclerotic Cardiovascular Disease Immed ate Cause (Final disease ∠xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and trans. Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of s certifica e has b rector, pase 2 sh death? performed' 1 🗸 Yes Nο ✓ Yes 2 pase the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other₄ Hospital: 1 Nursing Home 5 Residence 6 ✔ Other: Scene DOA Inpatient ER/Outpatient 3 this 1 🗸 Yes ٩ No 28c. Injury at Work? 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death After Certification: 1 V Natural Yes 2 No Pending the Funeral Director: hours after death 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide Could not be or Town, State) Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c, License number 29b. Signature and title of certifier August 7, 2008 O.C.M.E. - nu - imis 1 ml 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001 **OCME 2006**

Registrar

ORIGINAL

2008

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AUG 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** Charles Malloy 8:36 AM August 3008 25 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Co. Hagerstown Washington County Hospital | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Nonths | Days | Hours | Min. | 0.4 - 2.3 - 1.957 9. Birthplace (State or Foreign Country)
N • C • 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 2 M 2 □ F Director 577-80-1722 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28a-f shov 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 □ No MDTemple Hills Director P.G. 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 2 any injury or other traumatic event, the Medical Examination once. U.S.A. 20748 6300 Larwin Dr. Funeral 12. Was Decedent Ever in U.S Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Specify Black 1 Never Married 2 Married 1 □Yes 2 No Specify altimore, Maryland 21215-0036 ş 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)

Saftey Engineer Private College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Betty Cadlett Charles E. Malloy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 6300 Larwin Dr. Temple Hills, Md 20748 Michael Malloy/Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Riverdale Cremtory 08-25-200 Riverdale, Md 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of FacilityRonald Taylor II Funeral Am ure of Funeral Service Licenses 10583 Middleport Ln. White Plains, MD20695 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical s a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Difficile Examiner or Attending Physician; The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician Physician/Medical attending p use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) 4 Pregnant at time of death cate has been signed by the page 2 should be detached 9 I Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 1 ☐ Yes 2 ☐ No 1 □ Yes 2 No funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Ippatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 24 hours after death.

E Funeral Director: A letely filled in by the fu death. 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier within 24 ho To the Fune completely fi (Check only onel and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Do C 0 336 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 148 MUR 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Ve a **Physician** 22, 2008 3:10 August Juliet Forzani Nielsen /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Halethorpe 1829 Woodside Avenue 9. Birthplace (State or Foreign Country) New York If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days Hours **Funeral** Months 1 ☐ M 2 🔀 F 3/1/51 Director 067-38-9391 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 28a-f show 77 is marked other than "natural", or items 23a or 28a-f shov traumatic event, its Involcal Examiner resist by notified in 1 ☐ Yes 2 No Director **Halethorpe** MD Baltimore 10g. Citizen of What Country? 10e Street and Number 72 hours after death with USA 21227 1829 Woodside Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 🔀 No 11 Marital Status Black White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify If Yes, Give Year or Dates: White \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 and 2 should be filed within Elementary/Secondary (0-12) College (1-4or 5+) Library of Congress and Mental Hygiene. 5÷ Librarian 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Dominica Hugo Forzani 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health a Important: If item 27 is any injury or other trau Halethorpe, Maryland 21227 1829 Woodside Avenue Alan P. Nielsen / Husband 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of Barnets More and Cresting Color) 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 8/25/08 @ Loudon Park 21. Signature of Funeral Service Lidensee 22. Name and Address of Facility Loudon Park Funeral Home 3620 Wilkens Ave. Baltimore, Maryland 21229 CS Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List goty one cause on each line. Immediate Cause (Final disease or condition resulting in death) WEEKS NEUMONIA **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine sician and burial-transit Due to (or as a consequence of): attending physician for use as the burial Physician/Medical 23d Date of delivery yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ◯ No 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Year Month Day 5 Other (specify) ed by the a 9 Unknown 9 I Inknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown CARDIOVAS Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performe 1 □Yes 2 XNo 26. Place of Death (Check only one) Be (25. Was case referred to medical examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? funeral 27. Manner of Death 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide determined 4 ☐ Homicide

Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attendion physician and Box 68760, P.0. Division of Vital Records. filled in by To the twithin 2.

Baltimore, Maryland 21215-0036

Certification: To Medical

State Registrar

29a. Certifier

29b. Signature and title of certifier asanthalama 29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

108

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 516. N. ROLLING ROAD M. VASANTHA KUMAN

31. Date filed (Month, Day, Year) 2008 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) Day 8: 26 PM **Physician** wens 08 2008 Coucline /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Good Samaritan Hospital Baltimore N If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Birthplace (State or Foreign Country) 6. Sex Funeral Days Hours 1 □ M 2 F Min. 212-58-1163 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f shov Injury or other traumatic event, the find of Eventines sust by notified at 28a-f shov Yes 2 No od I Timore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 □Yes 2 No Baltimore, Maryland 21215-0036 Completed by Specify: Bac Jacquetire 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ARD 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health at
Important: If Item 27 is
any Injury or other trau Sequora) nams mes 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State MARYLAND -03-08 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 1 + cwell 21. Signature of Funeral Service Licensee 4600 liberty Her. Boto. No 2 207 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** 10 days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Premonia Sequentially list conditions, Due to (or as a consequence of cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last be executed burial-tran and Due to (or as a consequence of): Box 68760. Physician/Medical the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24a. Was an autopsy performed? 1 □ Yes 2 🕱 No 24b. Were autopsy findings available prior to completion of cause of death? adeno Carginoma certificate 1 ☐ Yes 2 X No of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐ Yes 2 X No 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 X Natural 5 ☐ Pending investigation within 24 hours after death.

To the Funeral Director: fcompletely filled in by the f 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 ★ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 ■ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) Res - 000 7-25-2009 1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMIR KA 20RY Blud, Raven Battimore, MD 21239 5601 Loch 32. Registrar's Signature Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2008^a 12:46 **Physician** August 25, Oliver Donald James /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, June 8, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Min. Months Days 1X M 2 □ F Illinois 87 Yrs 577-38-6711 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. ant: If Item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State ral", or items 23a or 28a-f show Exanimer must be mutilised at 1 ☐Yes 2 🕅 No Rockville Directo Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 20852 10440 Rockville Pike, Apt. 201 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married WWII White Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: 2 3 Widowed 4 Divorced Completed er than "natur, 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Berthal Mae Grantham Harvey Vivian Oliver မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
important: If item 27 is
any Injury or other trau 10440 Rockville Pike, Apt. 201, Rockville, MD 20852 Ina M. Oliver / Wife August 28 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bethesda, Maryland Montgomery Crematorium, Inc 2008 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 21. Signature of Funeral Service Licensee

Myselette Bannish M01305 7557 Wisconsin Avenue, Bethesda, Maryland 20814-2805 23a. Fart Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Pneumonia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) law requires that the death certificate be executed Exami attending physician and for use as the burial-trai Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 □Yes 2 □ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No certificate 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 \(\Boxed{\operator}\) Nursing Home 5 \(\Displies\) Residence 6 \(\Displies\) Other (Specify) Hospital: 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral c 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Mapner of Death 28c. Injury at Work? After t 5 Pending investigation 1 ANatural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide ö Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 4 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Road, Bethesda, Maryland 20814 M.D. Natasha P. Haag, 31. Date filed (Month, Day, Year) AUG 2 8 32 Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

08-06047

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

2008 27719

Charl	les Joseph		ill S - For State	State of Maryland	/ Departm	ent of F cate of D	ieaim and De <i>ath</i>	ı Memai i	Reg. N		000 211
	Dhysisis		egistrar I. Decedent's Name (First, Mid	idle,Last)					2. Date of Death Month Da		3. Time of Death
Me	Physicia ¹,Exami			. 0'Neil1				VIV	August 7, 20	ď8	1950 hrs
-			ia. Facility Name (if not institu	tion, give street and number	r)			Location of Deat	h	4c. County of Dea Baltimore Co	
			2905 Dunmore Road				Oundalk If Under 1 Yea	r If Under 24Hr	s 8 Date of Birth(N	1	Birthplace (State orunk
	Funeral		5. Social Security Number un	114	ge (In yrs. last bi	- ''	Months Day:		_	Fore	eign Country)
	Director			1X M 2 F		60 Yrs.		10	1101 239		
	any	-	Usual Residence of Decedent 10a. State 10b. Count		10c. City, Tow	n or Location	1				10d. Inside City Limits
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(rdeath with the Maryland or items 23a or 28a-f sho must be notified at once.	eral	11. Marital Status	12. Was Deceder	ent Ever in U.S.	13. Was	Decedent of His s, specify Cuba	spanic Origin? (: n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Am White, etc	nerican Indian, Black, :.
•	death or ite	Funeral	1 Never Married 2	1 X Yes	2 No		res 2 X No	specify:		Specify: 1	white
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	215-0036 be filed within 7 ntal Hygiene. rked other than ent, the Medica	Con	17. Father's Name (First, Mid	dle, Last)			unk	18.Mother's Nar	me (First, Middle, Ma	iden Surname)	unk
	be fill brinked vent,	Be				10h Mailing	Address (Stre	et and Number o	or Rural Route Numb	er, City or Town, St	tate, Zip Code)
	Baltimore, MD 21215-0036 Permit., Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	2	19a. Informant's Name/Relation						oad Dundal	k, MD 21	222
	, MD and 2 sho ealth and em 27 is raumati		20a. Method of Disposition	ulgii/illiciid	20b. Plac	ce of Disposit	ion (Name of c		Date	20c. Location - City	or Town, State
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	ords, P.O. Box 6876. w requires that the death certificate seem signed by the attending phy channel he datasched for use as the behavioral to describe the behavioral.	Physician/N	23b. Was decedent pregnant past 12 months?	t in the 1 Live birt	th	₂ Fe	tal death	3 Ectopic pre	egnancy	Month	Day Year
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	ds, equire een sig	Completed							24a. Was a		ere autopsy findings available or to completion of cause of
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	ital sician		examiner?	Hospital:	patient 2 E	R/Outpatien	3 DOA	Other N	ursing Home 5	Residence 6	Other: Scene
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	Division tal or Attending after death.	fica	2 Accident 3 Suicide 6	Could not be 28e. Place	of Injury - At hor	ne, farm, stre	et, factory, offic	ce building, etc.	28f. Location (S or Town, S	Street and Number (tate) 2905 D	or Rural Route Number, City unmore Rd - Ap
	Division of Vital Records, P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate Funeral layer death. Funeral Director: After this certificate has been signed by the attending physician.	Cortification	4 Homicide	determined (Specify)	house				A Dunc	lark, mu	
	Hosp 24 hc			ing Physician: To the best	of my knowledge	e, death occu	rred at the time	e, date and place nion, death occur	, and due to the caus red at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
,4	Division To the Hospital or Attend within 24 hours after death To the Funeral Director:	Modical		and mainer sta	ated.	alor myoodge		ense number			(Month, Day, Year)
		2	29b. Signature and title of o	cerumer				.C.M.E.		August 8, 20	•
			Yanulay 8	xithall. M	0	22.0)					
			30. Name and address of c	person who completed cause all. MD Assistant N	e of death (Item: Medical Exan		11 Penn Sti	eet, Baltimo	re, MD 21201		
		C4-		1000	gistrar's Signate		and of				
	Poo	Stat		8 2008	BIRES A	13/1	- Charles				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 10a-c,e,f per inf g884 10-1-08 vt. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** VERNON POINDEXTER /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) Examiner Plata Medica narles ivista Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min. Months 1 X M 2 □ F Yrs. 28, NOV 1918 VA 224-14-1823 89 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State MD • permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Inopartment of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modell Evanine must be notified at once. 1XYes 2 No WASHINGTON Charlotte Hall St. Mary's Director DC 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 29449 Charlotte Hall Rd. #2B 3525 POPE STREET, SE 20622 USA 20020 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S.
Armed Forces?
1 ∑Yes 2 No 1942 1 Never Married 2 Married dexter, Vernon 19115-Baltimore, Maryland 21215-0036 If Yes, Give Year or Date to 1945 1 ☐ Yes 2 X No Specify: Specify. BLACK δ 3 X Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) GENERAL ELECTRIC COMMERCIAL ARTIST 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be LILLIAN STAPLES HENRY NELSON POINDEXTER မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WASHINGTON, DC 20020 3525 POPE STREET, SE SHIRLEY DYER / NIECE 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 08-30-2008 LAUREL, MD MARYLAND NATIONAL 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility MARSHALL'S FUNERAL HOME OF MD 21. Signature of Funeral Service Licensee SUITLAND, MD 20746 Poind 4308 SUITLAND ROAD DONALD R. GRAY o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, at only one cause on each line. Approximate Interval Between Onset and Death 23a. Parr1 Enter the diseas show, or heart fallure. Immediate Cause (Final disease or condition resulting in death) COPIS **Physician** /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner be executed and burial-trar Due to (or as a consequence of): attending physician for use as the burial Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d, Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Day Month in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No o 9 Unknown à σ. 23e. Did tobacco use contribute to the cause of death? signed t I be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 5 2 No 3 Probably 4 Unknown 1 Yes Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes 2 No 1 🗌 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p. 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 R/Outpatient 3 DOA 1∐Yes 2XMNo 1 🔲 Inpatient Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 □ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier ☐ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brandywine, MD 20013 5900 Colu rive Lauras TIDOD 32. Registrar's Signature Date filed (Month, Day, State AUG 2 8 2008

DHMH 17 Rev 1/2001

Registrar

MR-43446

State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) Physician 2008 P^{M} 7:24 Benny J. Pasquariello August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Montgomery Holy Cross Hospital Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, July 28) 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F 73 1935 049-26-1920 Connecticut Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 1 ☐ Yes 2X No Director Maryland | Prince George's Bowie 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20720 United States 12406 Gladys Retreat Circle Funeral 12. Was Decedent Ever in U.S.
Armed Forces?
1 ∰Yes 2 □ No
If Yes, Give
Year or Dates: Korea 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify: White þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Consultant Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bernard Pasquariello Carmela Masseli ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jeanne B. Pasquariello/Wife 12406 Gladys Retreat Circle, Bowie, Maryland 20720 item 2 20b. Place of Disposition (Name of cemetery, crematory or other place)
Cedar Hill
Cemetery Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages Department of Important: If it any Injury or o August 29, 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Suitland, Maryland Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Ave., Rockville, Maryland 20850 21. Signature of Funeral Service Licensee ~ M01360 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 2 Hours Physician disease or condition resulting in death) Myocardial Infarction, Acute /Medical Due to (or as a consequence of): **Examiner** Atherosclerotic Cardiovascular Disease 20 Years Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed sician and burial-tran Due to (or as a consequence of): Box 68760, Physician/Medical phys IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred To the Hospital or Attending 1 X Natural 5 Pending To the Funeral Director: Aft 1 □Yes 2 □No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number D35112 August 25, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Paul B. Baker, MD

AUG 2 8 2008

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

32. Registrar's Signature

1500 Forest Glen Road, Silver Spring, Maryland 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year Physician 17 30 PM ACCUST 22 2008 PATTERSON CHARLES /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A BALTIMORE JOHNS HOPKINS BAYVIEW MEDICAL CENTER If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1**X** M 2□ F 11-15-1934 Maryland 73 215-30-0525 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Maryland | Baltimore Dundalk Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 7822 Kentley Road Funeral Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1XXyes 2 □ No If Yes, Give Year or Dates:1956-196.2 1 Never Married Married 1 ☐ Yes 2XXXNo Specify: White Specify. Baltimore, Maryland 21215-0036 ģ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Steel Worker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Julia Waldhauser Charles Patterson Sr. ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 7822 Kentley Road Dundalk Maryland 21222 <u>Patricia J. Patterson (Wife</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition ™Burial 2 □ Cremation 3 □ Removal from State Parkwood Cemetery 08-27-2008 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility uda-Ruck Funeral Home of Dundalk 21. Signature of Funeral Service Licensee Inc. 7922 Wise Avenue Dundalk Maryland 21222 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. Approximate Interval Between Onset and Death art1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death) VENTRICULAR Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy Year Month Day in the past 12 months? 5 Other (specify) 4☐Pregnant at time of death 2 □ No 1 ☐ Yes 9□Unknown 9 Unknown ģ 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been sig , page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? res 2 1 No 1□ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check onl one funeral director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Inpatient 3□ DOA 1 ☐ Yes 2 ER/Outpatient Certification: To After this 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28a. Date of Injury 28b. Time of 28c. Injury at Work? (Month, Day Year) Injury 5 ☐ Pending investigation M 1 ☐ Yes 2 ☐ No n 24 hours after death.

Re Funeral Director: Af 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🗎 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical within 24 hor To the Fune completely f 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier-RES-000

State Registrar SEAN

MD, PhD AGBOR-ENOH 32 degistrar's Signature 31. Date filed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

AUENUE, BALTIMORE, MARYLAND EASTERN

			1 - For State Registrar	State of Marylar			of Health a of Death	nd Mental Hy	giene Reg. No.	2008	27	723
	Physici	an	1. Decedent's Name (First, Middle, Last)	naton		- Transport		2. Date of Do Month	eath Day	Year 200 S	3. Time of	
	/Medic Examin		Beverly June Penni 4a. Facility Name (If not institution, give s FRANKLIN SQUARE)	street and number)	Ter		on, or Location of Sedal	Death	4c.	County of Death		
	Funeral Director		5. Social Security Number 6. Sex			If Under 1 Ye Months Da	ear If Under 2 ays Hours	4 Hrs. 8. Date of Bi Min. (Month, D 06-04-	ay, Year)		place (State on Intry) Sylvan:	
	Maryland a-f show	tor	10a. State 10b. County Maryland Baltimore	_	ty, Town or Lo	cation					10d. Inside Ci	
	vith the	Director	10e. Street and Number			10f. Zip Coo				zen of What Cou	•	
ဖွ	s 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. Are an arked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral	2517 N. Snyder Aven 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 Yes 2 No If Yes, Give		2121 Was Decedent If Yes, specify 0 1 □ Yes 2 ☒	of Hispanic Origi Cuban, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	0-	14. Race - Amer Black, White	ican Indian, etc.	
Maryland 21215-0036	n 72 hours "natural", edical Exe	Completed by	3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Educ (Specify only highest grade	Year or Dates:	16a. Dece	dent's Usual O	ccupation	of working		Specify: Whi		
212	d withii giene. er than	mo.	Elementary/Secondary (0-12)	College (1-4or 5+)	Homema		sur o a ,		Ow	n Home		
/land	should be filed vand Mental Hygie s marked other t sumatic event, In	To Be (17. Father's Name (First, Middle, Last) William L. Wolfkill	-				's Name <i>(First, Middle</i> L. G. Bay	e, Maiden S	Surname)		
Mari	12 sho th and 7 Is ma trauma		19a. Informant's Name/Relationship (Typ					or Rural Route Numi				
ē,	s 1 and if Health item 27 other t		Charles Penningtor 20a. Method of Disposition	20b.	Place of Dispo	sition (Name o	of .	nue Edgeme Date		ury land cation - City or T		
<u>E</u>	0 ~ = =		1 ⊠ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State I	k Lawn	natory or other Cemete	ry C	08-25-2008		timore,		
Baltimore,	permit. Pag Department Important: I any Injury o		21. Signature of Funeral Service License	e	i			Duda-Ruck Avenue Dun				
Į,	Physician /Medical		23a, art1. Enter the dise so, or complic shock, or heart failur. List only on Immediate Cause (Final disease or condition resulting in death)	cations that caused the dear e cause on each line.	th. Do not ent	er the mode of	f dying, such as c	Seles	arrest,		Approximate Interval Bet Onset and I	ween
	Examiner	er		Due to () as a conse	uence of	is hear	2/1/2 0				<i>0</i>	
8760, 4	cate be executed physician and the burial-transit	dical Examiner	Sequentially list conditions, if any, feeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec	uence of):	Mel	hores					
O. Box 68	ath certiti attending for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pregn 1	al death 3 □	☐ Ectopic pregr ☐ Other (specif			2	23d. Date of deli		⁄ear
ords, P.	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying cause	e given in Part I.			se contribute to		leath? Jnknown
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	Physician: this certific ral director,	To Be	25. Was case referred to medical examiner?	ospital: 1 🔲 Inpatient 2 🗆	l FB/Outpatier	nt 308000A	Othor:	of Death <i>(Ch</i> eck o <i>nly</i> sing Home 5 ☐ Res	-	COther (Space	i6.)	
n ot	nding Physician: th. : After this certifica : funeral director, p	on: T	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury		Injury at Work?	28d. Describe		- ' '	··· y /	
DIVISION	To tre hospital of Autending Pl within 24 hours after death. To the Funeral Director: After the completely filled in by the funeral	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, stre		1 ☐ Yes 2 ☐ No	28f. Location	(Street and wn, State)	d Number or Ru	al Route Num	iber,
-	ne nospita n 24 hours ne Funeral pletely filled	edical C	29a. Certifier (Check only one) 1 Certifying Phys 2 Medical Examin	ician: To the best of my kneer: On the basis of examination and manner stated.	owledge, deatl	h occurred at the	he time, date and my opinion, death	l place, and due to the h occurred at the time	e cause(s) , date and	and manner as place, and due	stated. to the cause(s)
	vithi To th	Me	29b. Signature and title of certification in the control of the certification in the certific	10 Van K. (ormis.	29c. Lic	cense number	129	29d. Date	e signed (Month	Day, Year)	
	V		30. Name and address of person who con	mpleted cause of death (Ite	n 23a) (Type,	Pant) De Da	ha de	P Bald	nap	No	2123	:1
	Sta	te	31. Date filed (Month, Day, Year)	08 32 pagistrar's Signa	No Pop	Select O			- 1			

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pennington

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 26 2008 Frankie Richardson August N. 9:25 a M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 5017 Leeds Avenue Baltimore Halethorpe 5. Social Security Number If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, MAR 19 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 1 XM 2 □ F 220-40-8274 64 1944 Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h. County 1 □Yes 2XNo York York 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 17404 USA 15 Old Mill Inn Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 □ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Richardson Virgie Brown Herman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5017 Leeds Avenue, Halethorpe, Maryland 21227 Nancy Reilly - sister 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/27/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee H. Name and Address of Facility Cremation Society of Maryland, Inc. 21228 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) STAGE LUNG CANCER with Metastai YR Due to (or as a consequence of) onditions, mmediate erlying r injury to (or as a consequence of) Last Due to (or as a consequence of) 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery nt pregnant 3 Ectopic pregnancy Month 2 months? Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) □No ificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ■Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☒ No 24a. Was an erred to medical 26. Place of Death (Check only one) sister's home] No 2 ER/Outpatient 3 DOA

Physician /Medical **Examiner**

the attending physician

Physician

/Medical

Examiner

Director

Funeral

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Completed

Be

PA

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mine.

To the Hospital or Attending Physician: The law requires that the death certificate be executed

Division or Vital Records, P.O. Box 68760,

	e e	Sequentially list c if any, leading to i
s the burial-transit	dical Examin	cause. Enter Und Cause (Disease of that initiated even resulting in death)
ched for use as	ıysician/Me	IF FEMALE: 23b. Was decede in the past 1 1 ☐ Yes 2 9 ☐ Unknow
should be deta	on: To Be Completed by Physician/Me	Part II. Other sign
ector, page 2 s	Be Compl	25. Was case refe
al dire	2	1 Yes 2
y filled in by the funeral director, page 2 should be detached for use as	al Certification:	27. Manner of Dea 1 Natural 2 Accident 3 Suicide 4 Homicide
<u></u>	<u>a</u>	29a. Certifier

29b. Signature and title of certifier

31. Date filed (Month, Day,

Year)

Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one)

State Registrar

within 24 hours after death.

To the Funeral Director

erson who completed cause of de litem 23a) (Type.

32 Regi

29c. License number

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2008 August Edwin Harvey Rabenold, Jr. 8:59A 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Suburban Hospital Bethesda If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 6. Sex Months Days Hours Min. 1 X M 2 □ F 193-16-2260 83 1924 Oct. 5, Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location 1 XYes 2 No Maryland Montgomery Potomac 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 11215 Seven Locks Rd. 20854 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?
1 ☑Yes 2 ☐ No 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 M Married If Yes, Give Year or Dates: 1943-46 1 ☐ Yes 2 🔀 No Specify 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 clerk cement co. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Edwin Harvey Rabenold, Sr. Hilda Golly 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cynthia LaCivita/ daughter 12301 Glen Mill Rd. Potomac, MD 20854 20a. Method of Disposition Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) 8/30/2008 nr. New Windsor, MD Winters Cemetery 22. Name and Address of Facilit Hartzler Funeral Home 21. Signature of Funeral Service Ligens athanne 6 E. Broadway Union Bridge, MD 21791 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOVASINL ATHEROSCLEROTIC UNKMIN disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year 5 ☐ Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an autopsy performer 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 ☐ Yes

Physician /Medical Examiner

permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m any Injury or other traum once.

Physician

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Examiner

Director

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Director

ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be multipled at

2 should be filed within 72 hours after death with In and Mental Hygiene. Is marked other than "natural", or items 23a or :

Baltimore, Maryland 21215-0036

the Maryland

the death certificate be execute attending physician and for use as the burial-tran

cate has been signed by the page 2 should be detached certificate director, this After th funeral

o. σ. Records, Vital of To the Hospital or Attending PI within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral Division

apenola.

Exami Physician/Medical IF FEMALE: 23b. Was decedent pregnant in the past 12 more
1 Yes 2 No
9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ Completed 1 ☐ Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ∐Yes 2 🗷 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar

31. Date filed (Month, Day, Year)



2008



SIDZ

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 25 **Physician** 2008 6:10p M August Matthew Racioppa /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Genesis Severna Park Severna Park Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Year) Months Hours 1 ▼ M 2 □ F Yrs **Director** 186-16-5349 83 Dec. 4,1924 PA Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, it a Medical Evariner reast be natified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 ☑ No Glen Burnie MD Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7543 Baltimore Annapolis Blvd. 21060 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc 1 MYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify ð Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn important: If Item 27 Is marked other tha any Injury or other traumatic event, the once. Designer Ship Building 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Patrick **NMN** Racioppa Tomacine Gennell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Spouse 7593 Baltimore Annapolis Blvd., Glen Burnie, MD 21060 Irma Racioppa 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State August 2008 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park Glen Burnie, MD 22. Name and Address of Facility Singleton Funeral & Cremation Svs. 21. Signature of Funeral Service Licensee M00918 2nd Avenue, S.W. Glen Burnie, MD 21061 twaller 23a. Tart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) hlachona **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed physician and s the burial-trans Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical attending p for use as t IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a 1 ☐ Yes 2 ☐ No 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>۾</u> 3 Probably 4 ☐ Unknown should 1 ☐ Yes Completed After this certificate has been funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1 □Yes To the Hospital or Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Aursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 🕮 o 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29b. Signature and title of certifier 1739036 10 Drive Chester, Mis 2/6/9 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ch worth use 2/08 31. Date filed (Month, Day, 32. Pogistrar's Signature Year) State Registrar

DHMH 17 Rev 1/2001

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気	Physici	an	1 State Registrar 1. Decedent's Name (First, Midd		nce H	-	rtificate o	t Death	2. Date of De Month	eath Day		3. Time o	
00	/Medic Examin Funeral Director	cal	4a. Facility Name (If not institution 208 Ashwood 5. Social Security Number 219-28-3755 Usual Residence of Decedent 10a. State 10b. Count 10a. State 10b. Count 10c. Street and Number 208 Ashwood 11. Marital Status 1 □ Never Married 2 ☑ Marital Status 1 □ Never Married 2 □ Never Married 2 □ Never Married	Road 6. Sex 1 [XM 2] F Baltimore Road 12. Was Deced Armed Forc 1] Yes 3 [Yes Give Fixed Present P	Age (In y 77 10c.		4b. City, Town Dt If Under 1 Ye. Months Day cation 10f. Zip Code 21222	Dundall Hours Mir	Augus th 8. Date of Bi (Month, Di March	rth (4c. (1) (4c. (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c. (1) (4c	2008 County of Death Baltime 9. Birthp County 31 Mary	ore blace (State yland Od. Inside C 1	Dity Limits s 2 ≰□ No
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Dalilliole,	permit. Pages 1 and Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Cther (21. Signature of Funeral Service)	(Specify) e Licensee	G Lee'	o. Place of Dispo cemetery, crei ardens d Di	osition (Name of matory or other p of Faith 2. Name and Ad uda-Ruck 922 Wise	olace) 1 Cem. 8/2 dress of Facility 2 Funeral	Date 28/2008 Home of	20c. Loo Ba Dund	altimore	own, State Mary 222	
)	The law requires that the death certificate be executed The law requires that the death certificate be executed The law requires that the death certificate and the law requirements that the law requirements the law requirements that the law requirements that the law requirements the law requirements the law requirements the law requirements that the law requirements the law re	dical Examiner	23a. Part1. Enter the disease, shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate and the second cause (Disease or injury that initiated events resulting in death) Last	a. Due to (or Due to (or c.	as a cons		rriso					Approxima Interval Be Onset and	tween Death
O. BOX 0	the death certifi y the attending ched for use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outco 1 □ Live bir 4 □ Pregnai 9 □ Unknow	h 2 □ F ntattime (etal death 3	⊒Ectopic pregna ⊒ Other <i>(specify)</i>			2	3d. Date of delive	ery Day	Year
r (coloo	w requires that been signed by should be deta	by	Part II. Other significant condi	tions contributing to dea	th but not	resulting in the u	nderlying cause	given in Part I.		\ \	se contribute to t	ne cause of pably 4	
ומו חפכ	an: The law tificate has b or, page 2 sh	e Completed	25. Was case referred to medic	eal				26 Place of D	24a. Was auto perf	opsy formed? 2 No	24b. Were auto prior to co death? 1 Yes	mpletion of	available cause of
	To the Hospital or Attending Physician: The law within 24 butus after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2 of the property of the funeral director, page 2 to the funeral director.	Certification: To Be	3 Suicide 6 Could	tigation d not be 28e. Place o	Injury Day Year	t home, farm, str	f 28c. lr	Other: 4 Nursing njury at Vork? Yes 2 No	Home 5 Res 28d. Describe	idence 6 how injury	d Number or Rura		mber,
)	To the Hospital or within 24 hours afte To the Funeral Dir completely filled in	Medical C	(Check only 2 Medica one) 29b. Signature and title of certif	ring Physician: To the ball Examiner: On the base and manner ier	is of exam r stated.	nination and/or in	vestigation, in m	ny opinion, death oc	curred at the time	, date and	place, and due t	the cause	
ą	Sta Registr		31. Date filed Mortil, Oly, Sca	who completed carse alle the 2008	of death (item 23a) (Type,	Print)	ense number 26833 uns Clar	les syl	ees	Bally	more	2120

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend State of Maryand / Department of Peraltin and Mental Tyglenet 1- State Amend #1, perMD, g882 8/28/08 Tertificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Alisa Spriggs 2. Date of Death 3. Time of Death Day Month Year **Physician** 1: 24 PM August 18 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Hospital Har bor enter If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | Sept. 7, 24, Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months 1960 1 □ M 2 🔽 F 47 Yrs Mary I and Director 220-80-3151 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County show ges 1 and 2 should be filed within 72 hours after death with the Maryla tr of Health and Mental Hyglene "
If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, Ite Medice Examination to a context trainfiled at 1√2 Yes 2 □ No Director MD Brooklyn 10f. Zip Code 10g. Citizen of What Country? 10e. Street an Plansera 1 3707 Baseal 21225 e Avenue USA Funeral Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. 11 Marital Status Black, White, etc. **Black** 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2X No Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) unk 16b. Kind of Business/Industry un Elementary/Secondary (0-12) College (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk -1111/c- Fulton A. Spriggs Geraldine Mae Easton ္ရ 19b. Mគ្គា**ឬ្តាស់**dr**អុ**ន (St**រក្នុង ក្រុម H**umber or Rural Route Number, City or Town, State, Zip Code) 21207 19a. In westene Springs Syp(Sister) Harber Hospit Hanover Street Baltimore, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 permit. Pages
Department of
Important: If It
any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 🕅 Other (Specify) in State 21. Signature of Fundal Strate Licensee Wade, 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street Director Baltimore, MD 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardia /Medical Due to (or as a consequence of Examiner Sequentially list conditions ner Due to (or as a consequence of) if any, leading to immedia cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last requires that the death certificate be executed burial-transi Exami and Due to (or as a consequence of) Box 68760, Physician/Medical the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Otner (specify) P.0. 9 Cloknown signed by 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 sactoremia 2 No 3 Probably 4 Unknown 1 ☐ Yes page 2 should Completed Rer 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 24a Was an autopsy certificate 1 ☐ Yes 2 ☑ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ M 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this funeral 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After the Hospital or Attending 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation within 24 hours after death

To the Funeral Director:
completely filled in by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 🗹 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WY 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) South Hanover street enter 2. Registrar's Signature 31. Date filed (Month, Day, Year) State

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Registrar

AUG 2 8 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last, Month Year **Physician** AUG 25 2008 /Medical 4b. City, Town, or Location of Death Examiner Facility Name (If not institution, give street and number) 4c. County of Death 1501 TIMOR Communi 14 CIK La lonsvi 7. Age (In yrs last birthday)
Yrs. If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth (Month, Day, 9. Birthplace Country) **Funeral** Days Hours Year) M 2□F 215-14-4314 **Director** Usual Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at actonsville 1 Yes 2 No Funeral Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe SA 12. Was Decedent Ever in U.S. Armed Forces? No Yes 2 □ No It As, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race · American Indian, 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours atter Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Ite any finury or other traumatic event, the Medical Examine 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ Specify: 3 Widowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ROCK Quarr College (1-4or 5+) Elementary/Secondary (0-12) V1101 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mam-19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) RO 527 GOVE There Baro M 200 Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 □Cremation 3 □Removal from State V ARULAN Itoly Kedeema-4 □ Donation 5 □ Other (Specify) MOST 21. Signature of Funeral Service Licenses 15RL 4600 WBERTY WO FO R5 110 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, shock, or heart failure. List only one cause or each line. Mascelar Disease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examiner burial-transit attending physician and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical use as the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) ed by the a detached f 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably → ☐ Onknown Completed . Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed2 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.
To the Funeral Director: After 1 Natural 5 Pending Injury 2 ☐ Accident investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 8005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

Year)

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39. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Month. DIJOA /Medical 4a. Facility Name (If not institution, give street and number) 4b. City Town, or Location of Death outty of Death Examine Gluns NUVSIL 700ac If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5/31/1929 7. Age (In yrs. last birthday Birthplace (State or Foreign Country) **Funeral** Days Year 1 M 2 □ F 79 220-20-0627 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland | Baltimore Halethorpe 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5127 Westland Boulevard 21227 United States Funeral 14. Bace - American Indian 12. Was Decedent Ever in U.S. Armed Forces 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 72 hours after 2 No 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify Specify: White \$ 3 ☐ Widowed 4 ☑ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry traumatic event, the Medical (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within the and Mental Hygiene.
7 Is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) 8 Proprietor Tavern 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anthony J. Scallio Mary F. Healy 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2
Department of Health at
Important: If item 27 is 1
any injury or any Frank V. Scallio / Brother 7230 Darby Downs, Unit G Elkridge, MD 21075 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cem. 8/29/2008 Baltimore, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Hubbard Funeral Home, 21. Signature of Funeral Service Licensee Inc. mail T Approximate Interval Between onset and Death 4107 Wilkens Avenue Baltimore, complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Lis immediate Cause (Final disease or condition resulting in death) 019 **Physician** /Medical Due to (or as a consequence of): Examiner 80 00 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Due to (or as a consequence of): attending physician Box 68760 Physician/Medical the as IF FEMALE for use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) P.0. the 9 Unknown 9 Unknown signed by ti d be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should Completed been s 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a Was an autopsy performed? Yes 2 10 No certificate has 1☐ Yes Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital 211 No 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA A Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After 1 Natural Injury 5 Pending 1 □ Yes 2 🗌 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29c. License number 29b. Signature and title of certi 29d. Date signed (Month, Day, Year)

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State Registrar 31. Date filed (Month, Day, Year)
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32 Registrar's Signature

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e South

State of Maryland / Department of Health and Mental Hygiene For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 25h Year 2008 Month **Physician** August 9:34A M Catherine Alice Snyder /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Seasons Hospice at Northwest Baltimore Randallstown 8. Date of Birth (Month, Day, Year) March 25, 1914 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min 1 □ M 2 🏝 F 219-05-9486 94 Maryland Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10h County 10c. City, Town or Location 10a. State 1 and 2 should be filed within 72 hours after death with the Marylan Health and Mental Hygiene.

Health and Mental Hygiene.

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Hat is marked other than "natural", or items 23a or 28a-f show ther traumatic event, I'm Medical Exertilium matter in conflict at Maryland Baltimore Baltimore 1 ☐ Yes 21 No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8306 Lages Lane 21244 United States Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Maryland 21215-0036 1 ☐ Yes 🏖 ☐ No Specify Specify.White à 3X Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry Gas & Electric 16a Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) and Standard Oil Accountant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Alice V. Lowe John L. Brandt ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 1603 Colony Road Pasadena, Maryland 21122 permit. Pages 1 and:
Department of Health
Important: If item 27.
any injury or other tra James Anders Saltimore, Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition XX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial Park 8-29-2008 Sykesville, Maryland 22. Name and Address of FacilityLoring Byers Funeral Directors, Inc. 21. Signatule of Funeral Service Licensee 8728 Liberty Rd., Randallstown, MD 21133-4784 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Subdura **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence off Examine Physician; The law requires that the death certificate be execute burial-trar Due to (or as a consequence of) attending physician Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnance for in the past 12 months?

1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 pe 1 Tyes 2 No 3 Probably 4 ☑ Unknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an nerformed certificate 1 ☐ Yes 2 ☐ No 1 □Yes 2 KNo 25. Was case referred to medical 26. Place of Death (Check only one) Be SEALOUS examiner' Other: 4 Nursing Home 5 Residence 6 MOther (Specify) HOSP (CE Hospital: 1≱Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) August 2, 2008 unknown 27. Manner of Death 28d. Describe Now injury occurred After t Hospital or Attending 1 □ Natural 5 Pending investigation e Hospin.... الم 24 hours after death. the Funeral Director; Af 1 ☐ Yes 2 No T-a 2. Accident ace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Mace of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 930(2 Lates Ln Route Number)

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28f. Location (Street and Nu 6 □Could not be 3 Suicide 4 Homicide 29a, Certifier completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 25, 2018 8 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAIN STREET REISTERSTOWN MD 25 16rce Deborah 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death IN WOOD August 1130 AM Year **Physician** SCOT 2008 20 /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Randallstown Hospital Morth WEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 8-10-1942 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 214-38-9625 66 NC **Director** Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location show 27 Is marked other than "natural", or Items 23a or 28a-f shot traumatic event, the Modical Exerciting a need to Director 1 ☐ Yes 2 No Reisterstown MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21136 USA 12010 Tarragon Road, Apt. I Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 ___X10 1 ☐ Yes 2 No African-American Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If Item 27 Is marked other the any Injury or other traumatic event, Its. ORCE. Tailor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles L. Scott Louise Williams ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sherri Jones/Daughter 3306 Southereen Road, Windsor Mill, MD 21244 20a. Method of Disposition
1 ☐ Burial 2 ②Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Metro Cranatory 8-27-08 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Wile Funeral Home P.A. of Balto.Co. 21. Signature of Funeral Service Licensee 9200 Liberty Road, Randallstown, MD 21133 23a. Cart I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Cardio-pulmonaly Arrest Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine and attending physician Physician/Medical the as for use a IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Vear 5 Other (specify) 1 □Yes 2 □ No the 9 Unknown ģ has been signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ tonknown page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate 2 4 No 2 NO 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 Z NO 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

Récords, Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p.

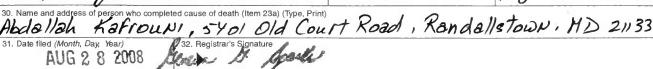
Maryland 21215-0036

Baltimore,

S

State Registrar 31. Date filed (Month, Day, Year) AUG 2 8 2008

29b. Signature and title of certifier



29c. License number

D65843

29d. Date signed (Month, Day, Year) August, 20, 2008

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DHMH 17 Rev 1/2001

State Registrar

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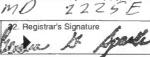
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31. Date filed (Month, Day,

30. Name and adduss of payson who completed cause of death (Imm 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND TIEM#31, PerDVR, G882, 8 / 28 / 08, WS

State of Maryland / Department of Health and Mental Hygiene 2 0 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year 12:30 p^{M} August 24. 2008 Selph Thomas E11wood 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 518 Carlsbad Court Lansdowne Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 ☑ M 2 □ F 62 30, 1945 Maryland 218-42-6754 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Baltimore Lansdowne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 518 Carlsbad Court 21227 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 Yes 2 □No If Yes, Give Year or Dates: Vietnam 1 Never Married 2 Married 1 □Yes 2 □ No Specify: White 3 Midowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) Meat Cutter Grocery Store 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Wilbur Selph Virginia (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Deborah Wright (Daughter) 2130 Willow Spring Rd., Dundalk, MD 21222 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Marvland National Cem 9/2/08 Laurel, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityLoudon Park Funeral Home 21. Signature of Funeral Service Licensee 3620 Wilkens Ave., Baltimore, MD 21229 23a. Parl - Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Chronic Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 ☐ Other (specify) I □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed Unt 1 □Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital-1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one)

/Medical Examiner that the death certificate be executed attending physician and for use as the burial-trar P.0. the been signed by t should be detach Division of Vital Records, cate has I page 2 s certificate

Physician

/Medical

Examiner

Director

Funeral

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Be Completed

2

Examiner

Physician/Medical

Completed by

Be

Medical Certification: To

Funeral

Director

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Modical Eventant in unation nutified at once.

Physician

Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu the

101

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

and manner stated.

D26656

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JORGE E ALDERON MP JORGE

4000 ANNAROUS Rd, Baltimon, MOZIZZZ

32. Registrar's Signatur 8 2008

Division of Vital Records, P.O. Box 68760,

		State of Maryland / Department of State of Maryland / Department of State	artment of Health and M	•	
		Registrar CE	rtificate of Death		. No.
Physicia	n	1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Year 3. Time of Death
/Medica		Leonard Augusta Sw		August	24 2008 7:32 P.M
Examine	er	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death
		Baltimore Washington Medical Center			Anne Arundel
Funeral		5. Social Security Number $\begin{bmatrix} 6. \text{ Sex} \\ 11\text{ M} \text{ N} 2 \end{bmatrix}$ 7. Age (In yrs. last birthday) Yrs.	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	
Director	-	Usual Residence of Decedent		July 18,	1917 Maryland
land ow	Ì	10a. State 10b. County 10c. City, Town or Lo	ocation		10d. Inside City Limits
Mary -f sh	ģ	Maryland Anne Arundel Glen B	urnie		1 ☐ Yes 2K∑ No
r 28a	Director	10e. Street and Number	10f. Zip Code	100	J. Citizen of What Country?
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examinat must be notified at	<u>_</u>	7873 Americana Circle Apt. 104	21060		U.S.A.
death ms 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13.	Uwas Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto	ecify Yes or No-	14. Race - American Indian,
after or ite	₫	1 Never Married 2 Married 1 X Yes 2 No	_	Rican, etc.)	Black, White, etc.
ral", c	<u>8</u>	3 ☑ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 □Yes 2XINo Specify:		Specify: White
72 hc	Completed	15. Decedent's Education 16a. Dece (Specify only highest grade completed) (Give	dent's Usual Occupation	na 16	b. Kind of Business/Industry
ithin ne. nan "	d.	Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of worki DO NOT use retired)	9	
ed willygier	ပို	3011	ver		Railway Express
be fill ital H id ott	Be	17. Father's Name (First, Middle, Last) Harry Clifton Swiger		(First, Middle, Ma	· · · · · · · · · · · · · · · · · · ·
ould Mer narke	၉		1 101	rence A.	
2 sh h and ris n			ng Address (Street and Number or Run		
permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once.	1				e, Maryland 21225
ges if of h		20a. Method of Disposition 1 △ Burial 2 □ Cremation 3 □ Removal from State	osition (Name of Imatory or other place)	pate 20	c. Location - City or Town, State
t. Pa tmer tant:					altimore, Maryland
Depar Mpol Iny Ir			2. Name and Address of Facility Go	nce Funer	al Service, P.A.
70 = 40 O	1		001 Ritchie Highwa	-	more, Maryland 21225
		23a. Part 1. Enter the disease of complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arres	Approximate Interval Between Onset and Death
Physician		Immediate Cause (Final disease or condition			Offset and Death
/Medical Examiner		resulting in death) Due to (or as a consequence of):	2 2 2 2 3		
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ed sit	Examiner	if any, leading to immediate cause. Enter Underlying Cause, Enter Underlying Cause, (Disease or injury			Ì
ecut and -tran	каш	Cause (Disease or injury that initiated events resulting in death) Last C			
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ding se as	Physician/Medi	IF FEMALE: 23c. If yes, outcome of pregnancy			
atten for us	ian	in the past 12 months? 1 Live birth 2 Fetal death 3	Ectopic pregnancy		23d. Date of delivery Month Day Year
he d	ysic	1 Yes 2 No 9 Unknown	Other (specify)		
that the ed by detac		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did toba	cco use contribute to the cause of death?
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been	ete				
e law has je 2 s	Completed by			24a. Was an autopsy	24b. Were autopsy findings available prior to completion of cause of
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iciar certif ecto	Be	25. Was case referred to medical examiner? Hospital:	Othori	h (Check only one)	
Phys this al dir	<u>٩</u>	T Inpatient 2 XEH/Outpatie	nt 3 LI DUA 4 LI Nursing Ho		ce 6 Other (Specify)
ding h. After funer	o o	1 Natural 5 ☐ Pending (Month, Day, Year) Injury	Work?	28d. Describe how	injury occurred
ttenc death ttor:	cat	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be determined determined 28e. Place of Injury - At home, farm, st		Oof Leastier (Otion	atandah ahaman Bari Bari Albari
or A after Direction by	Certification: To	4 Homicide determined building, etc. (Specify)	reet, lactory, office	City or Town,	et a <i>nd Number or Rural Route Number,</i> State)
pital ours eral filled		29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea	th occurred at the time, date and place	and due to the ca	(s) and manner as stated
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check only one) Check only one Che	nvestigation, in my opinion, death occur	red at the time, dat	e and place, and due to the cause(s)
o the	ĕ ⊠	29b. Signature and title of certifier	29c. License number	29	d. Date signed (Month, Day, Year)
F S F O		mb mb	063726		18,25,2008
180					-11
311		30. Name and address of person who completed cause of death (Item 23a) (Type, Kunmi Majekodunmi Mo IHole S		Tlen Rin	ne Ma 21061
Stat	e	31. Date filed (Month, Day, Year) 32. Registrar's Signature	C14117 1167 100 C		110 /110 -11001
Registra	_	AUG 2 8 2003	49		
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08-05963 Paul Stitely Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 27736

		or State			Certif	icate of	Death					Reg. No.	i.e.		3. Time of De	/ /
Physician/ Examine	1.	Decedent's Name (First, Midd Paul Stite									Date of De Month August 4	, 2008	Year	Doath	0743 hr	
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Funeral Director	5.	Social Security Number un	6. Sex		Age (In yrs. last	birthday) Yrs.	If Under 1	Year Days	If Under	Min.	8. Date of E			Co	hplace (State untry) ryland	
the filed within 72 hours after death with the Maryland that Hygiene. Hed other than "natural", or items 23a or 28a-f show any rent, the Medical Examiner must be notified at once.	10 Be Completed by Fullelal Director	Sual Residence of Decedent Da. State 10b. County MD Carr De. Street and Number 105 Carnival 1. Marital Status Never Married 2 3 Widowed 4 XD 15. Decedent's Education (Sp Elementary/Secondary (0-12 12 7. Father's Name (First, Midd Roland Rosco 9a. Informant's Name/Relatio Lisa Henry/da 20a. Method of Disposition	Oll Drive Married 12. Married 15 per pre pre pre pre pre pre pre pre pre	Was Deceded Armed Force X Yes Yes Yes Gates: aghest grade of College (1-4 O telly Print)	ant Ever in U.S. as? 2 No 2-66 completed) 1 or 5+)	13. Was If You during m	n 10f. Zip Constant Specific S	of Hisp Cuban, No ccupation ng life. I	specify: on (Give ki DO NOT u 8. Mother's and Num Stre	n? (Spee Puerto R ind of wo ise retire s Name (Emma ber or Ri	cify Yes or ican, etc.) rk done d) First, Middl Virg	10g. Citize No- 16b. K S e, Maiden S inia Number, Ci	en of What USA 14. Race - White, Specify: ind of Bus Chool Surname) Clem ty or Towr	Americetc. What Cou	ican Indian, B ite Industry ystem	Dity Limits
xaminer light or other l	2	1 Burial 2 Cremat 4 Donation 5 X Unites 21. S re of Funeral Sep 23a. P rt I. Enter thy disea e, fai are. List only one cau Immediate Cause (Final disea or condition resulting in death	Specify: 1 cedition or complicat se on each I	in stat de, Do lions that cau ine. PER GAS	te	Ba Do not enter to	Yame and A 1timo 1timo	re. dying,	MD such as ca	2120	1				Approxim Between	ate Inter
icate be execut physician and the burial - tra	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cau (Disease or injury that initiate events resulting in death) La UNPENDED IF FEMALE: 23b. Was decedent pregnant in past 12 months?	se c. Due	MENDED 23c. If yes, ou	nt at time of dea	eancy 2 F	etal death	3 sify)	Ectopi	c pregna			3d. Date o Month		Day	Year
res that the death certifications signed by the attending be detached for use as:	by Phy	Part II. Other significant co	nditions co	ontributing to					given in P	art I.					to the cause or robably 4	
law requires has been sig	Completed	OBSTRUCTIVE P										Was an autopsy performed?	,	Were prior death	autopsy finding to completion 1? Yes 2	ngs availa of cause
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DIVISION OF VICE INCOMES, pital or Attending Physician: The law require ours after death. reral Director: After this certificate has been si filted in by the funeral director, page 2 should be	Certification: 1	2 Accident 3 Suicide 6	Pending nvestigation Could not be determined	28e. Place (Specify)	e of Injury - At he		reet, factory	1	Yes 2 building,	No etc.	28f. Loca or To	tion (Street own, State)	t and Num	ber o	Rural Route	Number,
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St	ate	30. Name and address of per Russell Alexander 31. Date filed (Month Pay)	MD. A	ssistant M	e of death (item ledical Exan	niner 1	11 Penn	Stree	t, Baltin	nore, N	/ID 2120	1				<u> </u>

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\chi \)

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Medic	al _	Phoebe Steffey			4b City	Town, or L	ocation of		0		nty of Death	n
amin	er ⁴	4a. Facility Name (If not institution, give Fairhaven Nurs				kesvi				Ca	rroll	
eral	Ę	5. Social Security Number 6. Se		(In yrs. last bi	rthday) If Under Months	1 Year Days	If Under 2 Hours	Min. M	Date of Birtl (Month, Day ar 27,	1911.	9. Birth	nplace (State or Fore untry) (Land
ctor	-	Usual Residence of Decedent										10d. Inside City Lim
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tified	당	MD Carrol:	L	Syke	sville	0.17				10g. Citizen o	of What Co	11
oe no	Director	10e. Street and Number 7200 Third Avenue	e #028		10f. Zip		1784			-	JSA	,
nust			12. Was Decedent E	ver in U.S.	13. Was Dece			igin? (Speci	fy Yes or No	. 14. F		rican Indian,
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xam	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes	2 <u>X</u> J No	Specify:					
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event, the Medical Examiner must be notified at	Be	17. Father's Name (First, Middle, Last, John Grason Stef					, o. moule		Erwin		-/	
or other traumatic eve	유 .			10	9b. Mailing Addres	s (Street a	and Numbe	er or Rural	Route Numb	er, City or To	wn, State,	Zip Code)
traun		19a. Informant's Name/Relationship (Fairhaven Nursin		7	200 Thir	d Ave	nue	Sykes	ville,	MD 2	1784	
ther		20a. Method of Disposition		20b. Place	of Disposition (Na	me of	6)	Da	te	20c. Locatio	on - City or	Town, State
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any injury o	1	4 X Donation 5 ☐ Other (Special 21. Signature Funeral Service ice		<i>A</i> .	22. Name a	and Addres	s of Facili	lity	CEE 11	D = 1 + +		Ctroot
any		10000	////		Dal+in	0.70.0	MD	21201			unore	Street
		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused	the death. De	o not enter the mo	de of dying	g, such as	s cardiac or	respiratory a	rrest,		Approximate Interval Between
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57A	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as	a consequenc	e of):							
and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C	a consequenc	e of):							
cian a	cal E)		Duc 10 (61 do									
pnysii the t	dic	`	► d									
ding se as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome							23d	. Date of de	
atter I for u	cìar	in the past 12 months?	1□Live birth 4□Pregnant a								Month	Day Yea
y the sched	Jysi	9 ☐ Unknown	9□Unknown						1			
ed b dets	by Pi	Part II. Other significant conditions	contributing to death b	ut not resulting	g in the underlying	cause giv	en in Part	t I.				to the cause of dea Probably 4 □Unk
<u> </u>									11_	Yes 狐	- 3 <u> </u>	
uld be	Completed								24a, Wa aut	opsv	prior to	autopsy findings ava o completion of caus
s been signed by the attending physician and 2 should be detached for use as the burial-transit	E O								per 1∐ Yes	formed? 2 No	death′ 1 ☐ Ye	
has je 2	Be C	25. Was case referred to medical examiner?				100		ce of Death	(Check only	one)		
ate has page 2		1 Yes ≥ No	Hospital: 1 ☐ Inpati		Outpatient 3		3/0JIN			sidence 6 E how injury o		pecify)
is certificate has director, page 2	2	27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Inju (Month, Da	ury 28 ay Year)	b. Time of Injury M	28c. Injur Wor	ryat rk?]Yes 2[1	26G. Describe	e now injury o	Courred	
is certificate has director, page 2	11-	2 Accident investigation 3 Suicide 6 Could not		iuny - At home	, farm, street, fact			1 12	28f. Location	(Street and I	Number or	Rural Route Numbe
is certificate has director, page 2	11-		20e. 1 lace of III	tc. (Specify)	, iuiii, succi, idol				City or T	own, State)		
is certificate has director, page 2	11-	4 Homicide determine		t of my knowle	edge, death occurr	ed at the ti	ime, date	and place,	and due to th	e cause(s) a	nd manner	as stated.
is certificate has director, page 2	Certification: T	4 Homicide determine	Physician: To the best		and/or investigat	ion, in my	opinion, d	death occur	ed at the tim	e, date and p	lace, and d	ue to the cause(s)
is certificate has director, page 2	Certification: T	4 Homicide determine	Physician: To the best aminer: On the basis and manner s	of examinatior tated.								
is certificate has director, page 2	11-	4 Homicide determine 29a. Certifier (Check only (Check only (Medical Ex	a miner: On the basis of	of examination tated.		29c. Licens				- 1		onth, Day, Year)
ate has page 2	edical Certification: T	4 Homicide 29a. Certifier (Check only one) 1 Certifying I	a miner: On the basis of	of examination tated.		29c. Licens				- 1	Signed (Mo	onth, Day, Year)
is certificate has director, page 2	edical Certification: T	4 Homicide 29a. Certifier (Check only one) 1 Certifying I	aminer: On the basis of and manner s	death (Item 23		Dos	gos	4		- 1		onth, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND TTEM#23a, perPHYS of G882, 8/28/08 WS State of Maryland, Bepartment of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical Examiner 4a. Facility Name (If not institution, give 4c. County of Death more N/A If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 02/21/1923 **Funeral** 5. Social Security Number 1 Year Birthplace (State or Foreign Country) Sex 1 MX M 2 □ F Months Director 052-14-9038 85 NY Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 1 □Yes 2 No Director LUTHERVILLE MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 604 GOUCHER AVENUE 21093 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No WW. If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. WWII 1 Never Married 2 Married Specify: WHITE 1 □Yes 2 No 3 X Widowed 4 □ Divorced "natural", 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) SUPERVISOR U.S. POSTAL SERVICE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be in ment of Health and Mental ပ ABRAHAM SCHER MAY FROMKIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: if item 27 Is
any Injury or other trau
once. HOWARD SCHER / SON 275 W. PATRICK STREET, FREDERICK, MD 21701 timore. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetary ciematory of other place)
MEMORIAL PARK 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Speçify) 08/27/2008 REISTERSTOWN, MD e of Funeral Service Li 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or implies shock, or heart failure. List only on is that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, use on each line. Immediate Cause (Final **Physician** disease or condition /Medical resulting in death) Due to (or Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760. Physician/Medical use as attending plant for use as IF FEMALE: 23b. Was decedent pregnant in the past 12 months? ves, outcome of pregnancy 23d. Date of delivery 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day Year 5 Other (specify) □Yes 2□No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown this certificate has been 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ■ No 24a Was an page 2 2 **5**40 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 10 Impatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 □ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide n 24 hours a' EcertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, 30. Name and address of person who completed cause of death (Item 23a) 6 31. Date filed (Month, Day, Year) 32. Registrar's Signature State AUG 2 8 2008 Registrar

DHMH 17 Rev 1/2001

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Physician /Medical Examiner **Funeral** Director permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Experiment must be published as To Be Completed by Funeral Director ٤ Helen Baltimore, Maryland 21215-0036 Snyder Physician /Medical Examiner Medical Certification: To Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

1. Decedent's Name	e (First, Middle	e, Last)					2. Date of D			3. Time of Death
HE	LEN		Mi.		SNYDE	R	Month 8	2	ay Year	8 23 28 PM
4a. Facility Name (I	f not institution	, give street and nu	ımber)		4b. City, Town,	or Location of Dea	th	4	c. County of Dea	ath
FRANKLIN	Sauce	ie Hospi	Tal Cent	Er	Rosa	dale			3aLTIN	1018
5. Social Security N	umber	6. Sex v	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 24 Hr		irth	9. Bi	irthplace (State or Foreign
216-16		1□M 2 小 F	84	Yrs.	months buy	110013	01/26/	1924		rthplace (State or Foreign Country) MD
Usual Residence of 10a. State	Decedent 10b. County		100 City T	own or Loca	ation					10d. Inside City Limits
	1	E000	Toc. City, 1		ation					1 □ Yes 2 No
MD		FORD	l_	JOPPA				_		
10e. Street and Nur					10f. Zip Code			10g. C	itizen of What C	country?
12324 P	ULASKI	HIGHWAY				085			USA	
11. Marital Status	_	Armed F	edent Ever in U.S. prces?	13. W	as Decedent of Yes, specify Cu	Hispanic Origin? (ban, Mexican, Pue	Specify Yes or N rto Rican, etc.)	0-	 14. Race - Am Black, Whi 	
1 ☐ Never Marri 3 💢 Widowed		If Yes, G	ive	1 [⊐Yes 2⊠No	Specify:			Specify:	WHITE
3 tal vildowed	15. Decedent	Year or I	-	I6a Decede	ent's Usual Occi	Ination		16h	Kind of Business	n/Industry
	ify only highes	t grade completed)	î	(Give ki		during most of we	orking	100.1	And of Business	s/ilidustry
Elementary/Seco	ndary (0-12)	College (1-4or 5+)		TORE OW	*			LIQUOF	ŧ.
17. Father's Name (First, Middle, I	Last)			TONE ON	T	me (First, Middle	. Maide	·····	
MICHAEL			MICHALUK			ANN			UNKN	OWN
19a. Informant's Na		nip (Type. Print)				t and Number or F	Rural Route Num		or Town, State,	Zip Code)
BLANE TR	FRE2 /	GREAT NE				DRIVE,	KINGSVIL	Lt,	MD 210	087
20a. Method of Disp 1 X Burial 2 I 4 Donation	Cremation	3 Removal from	State B NAI	e of Disposi etery, crema ISRÁ	tion (Name of atory or other pla EL CEME	TERY 08/2	Date 26/2008	1	ocation - City o	
21. Signature of Fu			1	22.	Name and Add	ress of Facility	SOL LEVI	NSON	& BROS	S., INC.
see	D///.	une	h	8	900 REI	STERSTOW	N ROAD -	PI	KESVILLE	, MD 21208
23a. Part 1. Enter the shock, or hear	ne disease, or rt failure. List	complications that only one cause on	caused the death. [Do not enter	the mode of dy	ring, such as cardia	ac or respiratory	arrest,		Approximate Interval Between
Immediate Cause (Final n	Fre	echalo	in a T	h					Onset and Death
resulting in death)	1	Due to	(or a a consequen	ce of):	7					1
Cognestially list on	ditions	, Ren	ial Fail	Lure	Kid	ney DI	sease			
Sequentially list cor it any, leading to and cause. Enter Under	mediate	Due to	(ur as a cunsequen	ce ol).	7					
Cause (Disease or that initiated events	injury	c. ATT	al Fib	scill	ation					
resulting in death) L	ast	Due to	(or as a consequen	ce of):						
	,	d								
IF FEMALE:						70.0				
23b. Was decedent			tcome of pregnancy birth 2 Fetal de		Ectopic pregnar	icv			23d. Date of de	
in the past 12 1 ☐ Yes 2 ☐	_		nant at time of deat		Other (specify)			ļ	Month	Day Year
9 Unknown		9 0 0 1 1	10W11							
Part II. Other signif	icant conditio	ns contributing to d	eath but not resultin	g in the und	erlying cause g	iven in Part I.	23e. Did	tobacco	use contribute	to the cause of death?
							1 🗆	Yes 2	2 □ No 3 □ F	Probably 4 Unknown
							24a. Wa:		24b. Were a	autopsy findings available
							auto perl	psy ormed?	death?	
25. Was case referr	ed to medical	1				00 Bl 6 D-	1 Tes		o 1 □ Ye	s 2 No
examiner? 1 ☐ Yes 2 ☐	/	Hospital:	Inpatient 2□ER	/Outpatient	2000	hor	ath (Check only			
27. Manner of Death		28a. Date	of Injury 28	b. Time of			Home 5 ☐ Res			ecify)
1 ☑ Natural 2 ☐ Accident	5 Pending investig	(Mor	nth, Day, Year)	Injury	28c. Inji Wo	rk?]Yes 2. □No			ary occurred	
3 Suicide	6 ☐ Could n	ot be	of Injury - At home	farm stree	-	1100 20110	28f Location	(Street a	and Number or F	Rural Route Number,
4 Homicide	determi	ned build	ing, etc. (Specify)	, , , , , , , , , , , , , , , , , , , ,	,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, Sta	te)	tarar riodic riamber,
(Cneck only	1 Certifying 2 Medical E	Examiner: On the t	e best of my knowle pasis of examination	dge, death of and/or inve	occurred at the estigation, in my	time, date and place	ce, and due to the curred at the time	e cause(s) and manner	as stated. ue to the cause(s)
One)	0 .	and mar	ner stated.							
29b. Signature and	the of gentitier	NA	24			se number		290. D	ate signed (Mor	oth, Day, Year)
	n	~ / 1/	Hogn			50000			0/24/	O 3
30. Name and address	ess of person v		se of death (Item 23			0000	R 30	17	2 141 0	21237

State

Registrar

31. Date filed (Month, Day, Year)

AUG 2 8 2008

32. Registrar's Signature

08-06517 Terrell Scott Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 27740

		I- For State Registrar	Certific	cate of Death	n		Reg. No.		
Physicia		1. Decedent's Name (First, Middle,L				2. Dat	e of Death oth Day	Year	3. Time of Death
∵∽al Exami	ner	Terrell	Scott			Aug	gust 26, 200		0100 hrs
		4a. Facility Name (if not institution, g	ive street and number)	4b. City, T	own, or Location of	Death	4c	. County of Dea	ath
		University Hospital		Baltir	more			NIA	
Funeral		Social Security Number 6.	Sex 7. Age (In yrs. last b	oirthday) If Unde	er 1 Year If Under	24Hrs. 8. D	ate of Birth (MM/	DD/YYYY) 9. I	Birthplace (State or Foreign
Director		213-11-3502 1	MM 2 F 2	3 Yrs. Months	s Days Hours	Min.	00:122	1980	Country) Maryland
	-	-	2 F ~) 113.		1/7	ردمارارم	1401	27 0
Â.		Usual Residence of Decedent 10a, State 10b, County	10c. City, Tow	vn or Location					10d. Inside City Limits
* a		Maryland Balti			WEV				1 Yes 2 No
Aaryland 28a-f show 1 at once.	ğ		more 1111				T40- Citi	an of Mihat C	
Mary 28a	Director	10e. Street and Number	+ 1	10f. Zip				izen of What C	
th the Maryland 23a or 28a-f sho notified at once.		7 B Marble	Drive	1 2	1220		Un	ited S	12015
with ms 2.	Funeral	11. Marital Status	12. Was Decedent Ever in U.S.		nt of Hispanic Ongi			14. Race - Am White, etc	nerican Indian, Black,
death r ite	š	1 Never Married 2 Marri	ed Armed Forces?	ir res, speci	fy Cuban, Mexican,	, Fuerto Ricar			
ifter il", o	by F	3 Widowed 4 Divorc	ed If Yes, Give Year	1 Yes 2	No specify:			Specify: $oldsymbol{eta}$	lack
ours a		15. Decedent's Education (Specify	only highest grade completed) 16a	a. Decedent's Usual			one 16b. I	Kind of Busines	ss/Industry
72 hc	ete	Elementary/Secondary (0-12)	College (1-4 or 5+)	during most of wor		use retired)	10		0
336 thin re-	힏	12		La	bover		111	oving	Company
5-0036 lled within 7 Hygiene. I other than the Medica	Completed	17. Father's Name (First, Middle, La	st)		18.Mother's	s Name (First	Middle, Maiden	Surname)	
218 be file ntal H rked	Be	William	Scott		10	nine	Cart	240	
Men mar	2	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing Address	(Street and Num	ber or Rural F	Route Number, C	y or Town, Si	ate, Zip Code)
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland lealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once		Jenine Carter	- Mother	7 B M	arble]	Dr, Mi	iddle K	wer M	10 21220
nore, MD 21215-0036 gges I and 2 should be filed within 72 hours after nt of Health and Mental Hygiene. tt: If item 27 is marked other than "natural", other traumatic eyent, the Medical Examiner.		20a. Method of Disposition	20b. Plac	ce of Disposition (Nan		Date	20c.	Location - City	or Town, State
MOre Pages I ent of I int: If		1 Burial 2 Cremation	Tremoval nom state M	natory or other place)	L	1. 20	1.00	2.11	640
timen trant		4 Donation 5 Other Spec		vo CVEMA	2-1019	144, 30	1,00081 1.	Da 1 to.	
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service Lice	7/2 - 2	CA CUI	Address of Facility	ILLIA	ms 5	11/16	, MD 4, 4021224
				1270	Frednil	ton Pa	SS 450	- H2:	Approximate Interval
Physician 'Medical		failure. List only one cause on	mplications that caused the death. Do each line.	not enter the mode (or dying, such as ca	ardiac or resp	iratory arrest, sn	ock, or near	Between Onset and
∴xaminer	1 74		a. Multiple Gunshot Wounds						Death
		or condition resulting in death)	Due to (or as a consequence of):						
	_	Sequentially list conditions,	b. Due to (or as a consequence of):						
	aminer	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence or):						
	am	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		-				
ecuted and transit	ŭ		d.						
9 7 1	Physician/Medical	A 1 206	- 0000 0/F/00 mm						
760, ficate be eag g physician t the burial	Ned	Amend 28f, perMi	E G883 9/5/08 TT 23c. If yes, outcome of pregnan	ncv		-	23	3d. Date of deli	verv
87(tifica ng pl	In/N	23b. Was decedent pregnant in the		2 Fetal death	3 Ectopic	pregnancy		Month	Day Year
x 6 h cer lendi	icia	past 12 months?	4 Pregnant at time of death						
Box 687 ne death certific the attending p	ys	1 Yes 2 No 9 Unkno	g Unknown						
at the		Part II. Other significant condition	ns contributing to death but not resul	ilting in the underlying	g cause given in Pa	art I.	23e. Did tobacco	use contribute	e to the cause of death?
ires that the signed by a feetache	d by						1 Yes 2	√ No 3	Probably 4 Unknown
ords, w requir s been s should	Completed		*				24a. Was an		e autopsy findings available
COT law I has t	du						autopsy performed?	? deat	to completion of cause of h?
Re The icate	Ş						✓ Yes 2	No 1 🗸	Yes 2 No
of Vital Records, P.O. Box 68 in Prysician: The law requires that the death cert the thysician: The law requires that the death cert in the this certificate has been signed by the attendimental director, page 2 should be detached for use as	Be	25. Was case referred to medical examiner?	Hospital:		26.Place of Death	_			
Vit hysic this	2	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 🗸 ER		OOA Other	Nursing Hor			Other:
	Ë	27. Manner of Death	(Month Day Year)		28c. Injury at Work	Sub	Describe how in ject shot	ijury occurred	
	ij	1 Natural 5 Pendin 2 Accident Investig	9	349 hrs	1Yes 2 🗸	NO			
VIS or At fer d firect in by	ij	3 Suicide 6 Could	28e Place of Injury - At home	e, farm, street, factor	y, office building, et	tc. 28f.	Location (Street	and Number o	Rural Route Number, City
	Certification:	4 V Homicide determ				Kels	Erive, Middle	r filter, ldf	Baltimore, MD
Division To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy	sician: To the best of my knowledge,						
thin 2 the mplet	Medical	one) 2 Medical Exami	ner: On the basis of examination and/	or investigation, in m	y opinion, death oc	curred at the	time, date and p	lace, and due	to the cause(s)
To with To Com	Me	29b. Signature and title of certifier	and manner stated.	29	lc.License number		29d	. Date signed	(Month, Day, Year)
		1.11 1	1 1 20	Í	O.C.M.E.		Au	ugust 26, 20	008
		14M/ C	7 / //	20)	· · · · · ·				
		30. Name and address of person w Russell Alexander MD.	ho completed cause of death (Item 23 Assistant Medical Examin		Street, Baltimo	ore MD 21	1201		
			Assistant Medical Examina 32 Registrar's Signature		Caroon Damini				
S Regis		31. Date filed (Month, Day, Year)	32 Registrar's Signature	Acres 1				DOME	
17.57	للتقته	BUUAU M	/中中中 BARDWINELES TALE	Comment of the same				DGME	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No.2 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Yea **Physician** rezevant 2not/Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9-27-1951 5. Social Security Number 6 Sex Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral Days Hours Min 1**∏**M 2□F 577-70-6456 56 MD Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show the Medical Examiner must be notified at MD N/A Baltimore 1 ☐Yes 2 ☐ No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral Road Apt F

12. Was Decedent Ever in U.S. Armed Forces? J S A 14. Race - American Indian. 21244 1614 Cantwell Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 Never Married 2 Married 3 Widowed 4 Divorced 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No þ Specify: Black Completed 16a Decedent's Usual Occupation 16h Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade years Disabled Disabled 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any linjury or other traumatic evonce. Walter Trezevant Mildred Maith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9593 Shirewood Ct Balto, MD 21237 Jerelle Trezevant-Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Purial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8-30-08 Randallstown, MD King Memorial Pk 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March East F/H Dlady 1101 E. North Avenue Balto, 0 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (as a consequence of) Examiner Per Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a co quence of) Examine Division or Vital Records, P.O. Box 68760% Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 I Inknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? <u>Ş</u> 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an autopsy performed? Yes 2 No 1Γ Yes Hospital or Attending Physician: director, Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3D DOA 1 ☐ Inpatient 2 ☐ ER/Outpatient s after dec. aral Director: After ... by the funeral dir Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide within 24 hours a To the Funeral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, P

Registrar

State

31. Date filed (Month, Day, Year)

AUG 28

2008

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 2 0 8 Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 27 2008 4:14 August Josephine Tippett Lauretta /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner <u>Baltimore</u> 719 Maiden Choice Lane, HR-627 Catonsville If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 □ M 2 X F July 1 1927 81 Yrs. Wash., D.C. 579-32-9643 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10c. City, Town or Location 10b. County or iteme 23s or 28s-f show 1 TYes 2X No Funeral Director MD Baltimore Catonsville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 719 Maiden Choice Lane, HR-627 be filed within 72 hours after death 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc ☐Yes 2MNo 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Completed by 3 Widowed 4 Divorced "natural", 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Pages 1 end 2 should be filed within nent of Health and Mental Hygiene. ent: If Item 27 ie marked other then ury or other traumatic event, the Ma Elementary/Secondary (0-12) College (1-4or 5+) Secretary Financial 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Latimer Josephine Victoria Goode Tippett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Victor Harwick - friend 719 Maiden Choice Lane, BR-134, Catonsville, MD 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State permit. Page Department of Important: If eny inlury or once. Metro Crematory, Inc. 8/28/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea Steven H. Williams 22. Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore. MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heef failure. List only one cause on each line. ancle VRF mmediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, fary leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy Year Month Day in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No Division of Vital To the Hospitel or Attending Physicien: within 24 hours after death.
To the Funerel Director: After this certifica 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 ☐ Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗌 Homicide → Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

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DHMH 17 Rev 1/2001

Registrar

AUG 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year 7:00 PM Travers 2008 Nellie AUGUST 26 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Baltimore Keswick Nursing Home If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 08 09 18 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 1□ M 💥 🗆 F ٧A 226-07-5539 90 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1X Yes 2 No NA Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number U.S.A. 21215 3452 Dolfield Ave 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 11, Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Home Housewife na 7th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Frances Branch Joseph Theett 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 21244 7101 Bexhill Road, Baltimore, Md Moses Jones-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) King Memorial Park 9/2/08 Woodlawn, 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licensee 21215 me 4300 Wabash Ave, Baltimore, 23a. Part1. Enter the disease, or complications that shock, or heart failure. List only one cause on caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Unknown CErebrovascular accident Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of)

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

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of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the M

permit. Pages 1 Department of H Important: If ite any Injury or ot

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Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Division or Vital Records, P.O. Box 68760, ed by the attending physician detached for use as the buria funeral director, within 24 hours after death To the Funeral Director:

Completed by Physician/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or as a consequence						
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	23c. If yes, outcome pf pregnancy 1 □Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	h 3 ⊟Ectopic 5 ⊟ Other (s			23d	. Date of delivery Month Day	Year
d by Pr	Part II. Other significant conditions co	ntributing to death but not resulting	in the underlying	cause given in Part I.		l tobacco use] Yes 2 □ N	contribute to the ca	
Complete	DYSLIPIOEMIA SEIZURE DISOR	JER_			per	s an 2 opsy formed 2 2 No	24b. Were autopsy prior to comple death?	tion of cause of
Be (25. Was case referred to medical			26. Place	of Death (Check only	one)		
0	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/O	outpatient 3 🗆 🛭	OOA Other: 4 Nu	rsing Home 5 🗆 Re	sidence 6	Other (Specify)	
ation: T	27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation		Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐		e how injury o	occurred	
Medical Certification	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of injury - At home, f building, etc. (Specify)	farm, street, facto	ory, office	28f. Location City or 7	(Street and Nown, State)	Number or Rural Ro	oute Number,
dical (29a. Certifier 1 Certifying Phy (Check only one) 2 Medical Exam	vsician: To the best of my knowledginer: On the basis of examination a and manner stated.	ge, death occurre and/or investigati	ed at the time, date ar on, in my opinion, dea	d place, and due to the third due to the time.	ne cause(s) ar ie, date and pl	nd manner as state lace, and due to the	d. e cause(s)
Me	29b. Signature and title of sertifier		2	29c. License number		29d. Date s	signed (Month, Day	, Year)

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Registrar

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filled in by

completely

29b. Signature and title of egrtifier

31. Date filed (Month, Day, Year)

Falls

MO

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32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

Salvja MO

AUG 28

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Year 1:05 A^M **Physician** Frank J. Tempera 22, 2008 August /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner N/A Baltimore City Joseph Richey Hospice Center If Under 1 Year _ If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) Funeral Months Days Hours Min. 1 → M 2 □ F Yrs. 4,1918 Maryland 90 Jan. 215-07-0034 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 28a-f show Department of Health and Mental Hyglene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any lijury or other traumatic event, its Medical Examinac must be retified at once. 1 ☐ Yes 2€No Director Dundalk Maryland Baltimore Pages 1 and 2 should be filed within 72 hours after death with the 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21222 United States 41 Waterview Road Funeral 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. No If Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No White Baltimore, Maryland 21215-0036 Specify Specify: à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Insurance 12 Years Insurance Agent 18. Mother's Name (First, Middle, Maiden Surname) Unkn. 17. Father's Name (First, Middle, Last) Be Anna Evandro Tempora 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 41 Waterview Road Dundalk, Maryland Mr. Richard Tempera (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville Veterans Cem. 8/27/2008 Crownsville, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. o Funeral Service Lige an 7922 Wise Ave. Dundalk, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 6/10/08 metast2 **Physician** /Medical Due to (or as a consequence of) Examiner Stz Sequentially list conditions Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last The law requires that the death certificate be executed burial-trar Due to (or as a consequence of) Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death 9 ☐ Unknown 5 Other (specify) 1 ☐ Yes 2 ☐ No Records, P.O. ed by the a 9 Unknown 23e. Did tobacco use contribute to the cause of death? s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No directe 24a. Was an certificate has b rector, page 2 sh 2 No. 1 □ Yes the Hospital or Attending Physician: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To After this Division of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

31. Date filed (Month, Day, Year) AUG 2 8

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** 2008 16 Turner George /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Mayland Medical Center Baltimore 8. Date of Birth (Month, Day, Year 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 ☑ M 2 ☐ F Apr 17, Mary1and 217-66-4346 52 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once. 1XYes 2 No Baltimore MD Director 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21229 816 Mount Holly Street Funeral 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married _ 2 ☐ Married Specify: black 1 ☐ Yes 2 X No Specify. Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced Completed by Year or Dates: unk 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mamie Tyson George Turner Sr ۵ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
5999 Emerson Street #801 Bladensburg, MD 20710 19a. Informant's Name/Relationship (Type. Print) Mamie Tyson/mother Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 NOther (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Wad, Baltimore, MD . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 23a. Part . shock Immediate ause (Final disease or cyldition resulting in de th) meumonia Physician /Medical Due to (or as a consequence of): Examiner AIDS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine e Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Puneral Director: After this certificate has been signed by the attending physician and physician and s the burial-trans Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical as attending t If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) ☐Yes 2☐No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? Yes 2 No 1☐ Yes 26. Place of Death (Check only one 25. Was case referred to medical examiner? Be Hospital: Other: 1 Yes 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 inpatient P 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 27. Manner of Death (Month, Day Year) Injury 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide completely filled in by determined 4 Homicide 1 Zertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

To the I

29c. License number

AU4176435K18920

Greene Street, Baltimore

29d. Date signed (Month, Day, Year)

O8-04379

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No.

2008 27746

		- For State egistrar					Certifica	ate of l	Death					Reg.	No.			
Physicia		I. Decedent's Nam	e (First, Midd	lle,Last)									Date of D Month	D.	ay \	Year	3. Time (of Death 7 hrs
edical Examir		Albert											June 7,	2008		tu of Don		7 1113
		4a. Facility Name (400 East C			treet and no	umber)		4t	Baltimo		ocation of					ty of Dea		
Funeral	7	5. Social Security I	Number un	6. Sex		7. Age (In	yrs. last bir	thday)	If Under		If Under					YY) 9. B Fore	irthplace (S ign	State orunk
Director				1X N	1 2 F		60	Yrs.	Months	Days	Hours	Min.	Apr 3	3,	1948		Country)	
_	ŀ	Usual Residence o	f Decedent														I 40-l Inc	ide City Limits
any		10a. State	10b. County			10c.	City, Town											res 2 No
nd Show	_	MD				-	Ba1	timo	re									165 2 140
laryla	Director	10e. Street and Nu							10f. Zip C		202			10g.	Citizen of US		untry?	
ith the Maryland 23a or 28a-f show notified at once.	吉	400 E.	Chase	Str	eet						202							
with ns 23	la l	11. Marital Status		l l	12. Was De Armed F	cedent Ever		13. Was	Deceden s, specify	t of Hisp Cuban.	anic Örigir Mexican, İ	n? (Spec	cify Yes or	r No-		ace - Ame /hite, etc.	erican India	an, Black,
or iter	Funeral	1 Never Marr		Married	1 Yes	2	unk No						,			. h	lack	
after	J A	3 Widowed			Yes, Give Ye or Dates:				Yes 2			and of uso	de donot1	n Idla	Speci 6b. Kind o			unk
nours natur	ed t	15. Decedent's E					ed) 16a.	Decedent during mo	st of work	ing life. I	DO NOT u	ina of wo	d)	III (OD. MINU O	Dusines	3/11/403/19	G111
16 n 72 l nan "	ompleted	Elementary/Sec	ondary (0-12		_	(1-4 or 5+)												
withi withingiene	E .	unk 17. Father's Name	(First Middle		nk				unl	c 1	8.Mother's	Name (First, Midd	ile, Ma	iden Surna	ame)		unk
filed filed ed out	ပ	II. Fathers Maine	(Tirst, Wildan	e, Last)					GIII	•								
21215-0036 nould be filed within 72 hours after id Mental Hygiene is marked other than "natural", tite event, the Medical Examiner	0 8	19a. Informant's N	lame/Relation	nship (Typ	oe, Print)		1 19	9b. Mailing	Address	(Street	and Numb	per or Ru	ral Route	Numb	er, City or	Town, Sta	ate, Zip Coo	de)
		O.C.M.	Ε.				7	111	Penn	Str	eet E	Balt:	imore	, M	D = 2	1201		
ore, MEss 1 and 2 s of Health as If item 27 her traums	ı	20a. Method of Di	sposition		7		20b. Place	of Disposi		e of cem	etery,		Date		20c. Locat	ion - City	or Town, S	State
altimore, mit. Pages 1 ar epartment of Her portant: If ite jury or other tr			Cremation X Other			from State	0/0///	2101) 01 01	ю. р.ссс,									
Baltimo permit. Page Department of Important: injury or ott	1	4 Donation	uperal surgic	edicen	ale.	Direc	tor	S2t N	ame and	Harb	of Facility	oard	655	W.	Ba1t	imor	e Str	eet
E Per Co	i	X/1100	1.1	11	1100	1_		Bal	timo	re,	MD :	2120	1				-	
Physician		23a. Part I. Enter	he disease,	or compli	cations that	caused the	death. Do i	not enter th	ne mode o	f dying, s	such as ca	ardiac or	respirator	y arres	st, shock, o	r heart		een Onset and
Medical Examiner		Immediate Cause		^	therosci	erotic Cai	rdiovasc	ular Dis	ease co	mplica	ated by	Enviro	nmenta	І Нур	ertherm	ia	- 19	Death
Adminici		or condition resul	ting in death)	D	ue to (or as	a conseque	ence of):											
	<u></u>	Sequentially list of any, leading to		b	ue to (or as	a conseque	ence of):										1	-
	Examiner	cause. Enter Und	derlying Caus	e c.										_			-	
d sit	xar	events resulting i			ue to (or as	a conseque	ence of):											
recuted and rand		UNDENDE	-	d	AMENDE													
760, cate be ex physician the burial	ledical	UNPENDE	U				f								23d. Da	ate of deli	verv	
3760, ificate bing physics s the buns	≥	IF FEMALE: 23b. Was deceder		the	1 Live	s, outcome c e birth	or pregnanc	₂ Fe	tal death	3	Ectopic	pregnar	ncy		Mor		Day	Year
Box 68 death certifule attending	Physician	past 12 mont			4 Pre	gnant at time			her (Spec	cify)								
Bo e deat the at ed for	hys	1 Yes 2			9 Unl	nown					t a sin De		220	Did tob	nacco use	contribute	e to the car	se of death?
that the death certificate by the attending detached for use as:	by P	Part II. Other sig			contributing	; to death bu	it not result	ing in the i	underlying	cause g	jiven in Pa	ITL I.						4 ✔ Unknown
S, P.C uires that n signed	l b	Chronic F	Alcoholism											Was a				indings available
ord: w requires been should	olet.													autops	sy .		to complet	ion of cause of
Reco	E O	Per per per per per per per per per per p											Yes 2		1 🗸		2 No	
tal Re(ian: The certificate	Bec	25. Was case referred to medical																
of Vital Records, ng Physician: The law requir ther this certificate has been s meral director, page 2 should I	다	1 Yes	2 No		ospital:	Inpatient		/Outpatien			Other ₄		g Home		Residence low injury o		other: Scene	e
of ing Pf After uneral									-	- l:	Subject	cribe i	osed to f	not tem	perature	es		
ttend Heath.	aţi	2 🗸 Accident		ending vestigatio	Jun 7	, 2008	13	30 hrs					205 1 005	tion /C	Stroot and I	Number o	r Bural Bo	ute Number, City
Division tal or Attendir is after death.	Certification:	3 Suicide		ould not b	e	lace of Injury		, farm, stre	et, factory	, описе в	ouilaing, et	tc.	or To	own, Si	tate) se Street,	Baltimo	re. MD	sto reambon, only
Divi	g	4 Homicide	3		(best of my kr			ared at the	timo d	ate and pl							
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	ical	(Check only	✓ Certifying ✓ Medical E	Physicia xaminer	an: To the l :On the bas	best of my kr sis of examin	nowledge, o ation and/o	geath occu or investiga	irred at the ation, in m	y opinior	ate and pro n, death oc	ccurred a	t the time	, date	and place,	and due	to the caus	e(s)
To t To t	Medical	29b. Signature a			and manne	er stated.					se number						(Month, Da	
	_	1	1.	101	MAL)				O.C.	M.E.				June 8	3, 2008		
		30. Name and ad	Idraes of por	son who	ompleton	ause of deal	th (Item 23:	a)					_					
		Laron Loc				ical Exam		l11 Pen	n Street	, Baltii	more, N	/ID 212	.01					
	tate				32/	Registrar's	Signature	A	of the		_							
Regis			AUG 2	8 20	UO A	Colina	15	1900	436									

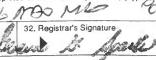
		For State	State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 201						08 27747		
		Registrar 1. Decedent's Name (First, Middle, Last,	Middle, Last) 2. Date of Death					3. Time of Death			
Physicia /Medic		JOHN F	WHITNI	EY -	SR.		AUGUST	27 2	Year 12:30 PM		
Examin	er	4a. Facility Name (If not institution, give BALTI MORE WASHINGT		- 10-0	A 11	Location of Death	1	4c. County o	Λ		
Funeral		5. Social Security Number 6. Se	x 7. Age (In yr	s. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi (Month, D 8-8-19		9. Birthplace (State or Foreign		
Director		212-34-4930 15 Usual Residence of Decedent	Øм 2□F 72	Yrs.	Worldis	10010	8-8-19	36	MD		
ryland how		10a. State 10b. County Anne Aru:		City, Town or Loc	ation Glen	Burnie			10d. Inside City Limits		
he Ma 28a-f s	ecto	10e. Street and Number			10f. Zip Code		1	10g. Citizen of W	1 □Yes 2 🕅 No		
h with 1	al Dir	459 Longtown Cour	t		21061			US			
should be filed within 72 hours after death with the Maryland should be filed within 72 hours after death with the Maryland and Mental Hygiene. I marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examiner must be notified at	by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Married	Armed Forces? 1 ☐Yes 2 X No If Yes, Give	1 □Yes 2 🕅 No If Yes, Give 1 □ Yes 2 🕅 No		dispanic Origin? (S an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)	Black	14. Race - American Indian, Black, White, etc. Specify: white		
P hours		3 ☐ Widowed 4 🖾 Divorced	Year or Dates:	16a. Deced	ent's Usual Occup	pation		16b. Kind of Bus			
ithin 72 ne. nan "na	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Give kind of work done during most of work life. DO NOT use retired)			Westinghouse						
filled wi Hygier tther th		12 17. Father's Name (First, Middle, Last)		-	Inspector	~	ne (First, Middle	e, Maiden Surname			
uld be i vental rked o tic eve	To Be	John Franklin Whi	tney Sr.			Flore	nce B	arlow			
and 2 shou alth and N 27 is ma er trauma		19a. Informant's Name/Relationship (7) Mr Michael Whitney				and Number or Ru Dr Glen		ber, City or Town, S MD 21061	State, Zip Code)		
permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Mental Hygiens. Important: If Item 27 is marked other than "natural"; or i any hijury or other traumatic event, I'm Medical Examinante.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ⚠ Other (Specify,	Removal from State		sition (Name of natory or other place on Cemete		Date / 2008	Glen Bur	City or Town, State		
permit. Departi		21. Signature of Funeral Service Linens	M01		Name and Addre	N 1	rkley Ri len Bur	uddick Fu nie MD 21	neral Home PA .061		
		23a. Part 1. Enter the dise in , comp shock, or heart failure. List only o	lications that caused the dene cause on each line.	eath. Do not ente	er the mode of dyi	ng, such as cardiad	or respiratory	arrest,	Approximate Interval Between On <u>s</u> et and Death		
hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Odelb Due to (or as a cons	egere	tong des	ter	ugud	ague	24 fus		
Examiner		Sequentially list conditions	b Lestie	- et	och.				24-48-Re		
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	equence of):	ice of):				2-3 1			
icate be executed physician and the burial-transit	Exa	that initiated events resulting in death) Last	Due to (or as a consequence of):			from egales			- Jun		
cate be physici the bu	dical	•	d								
leath certifi attending for use as	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pre					23d. Date	e of delivery		
at the death by the atte	Physician/Me	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown						nth Day Year		
es the	ρ	Part II. Other significant continuous contributing to death out not resulting in the underlying cause given in Part I.						ibute to the cause of death? 3 Probably 4 Unknown			
law requir nas been si	Completed						24a. Wa	opsy p	Vere autopsy findings available prior to completion of cause of		
ician: The law certificate has							1 □ Yes	2 No 1	leath? □Yes 2□No		
yslcla yslcla is certi	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 4 Nursing Home 5 Residence 6 Other: 6 Ot							er (Specify)			
nding Physician: th. r: After this certification of funeral director, p	ation: T	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year	28b. Time of	28c. Inju Wo			e how injury occurre			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A	Certification:	3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 4 ☐ Homicide 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Num City or Town, State)						(Street and Number own, State)	er or Rural Route Number,		
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	Medical (
vithin To th	Me	29b. Signature and title of certifier			29c. License number			29d. Date signed (Month, Day, Year)			
r Y		· Clar	callen		Doc	714147		August	11 2008		
6		30. Name and address of person who of	ompleted cause of death (Item 23a) (Type,	Print)	300	6/10.	Ber.	21061		
Sta		31. Date filed (Month, Day, Year) AUG 2, 8, 200	32. Registrar's S	gnature	ness i	ر		2000			
Regist	ar	AUG Z 8 Zee	IN THE PARTY OF	1	27.5						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 02 Year Month WILLIAMS **Physician** CERTRUDE 08 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Baltimore Genesis Cromwell Nursing Home Towson Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Min. Days Hours Months 1 ☐ M 2 ☐ ₩ Yrs. 11/24/1926 Virginia Director 229-24-5452 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Wedical Examinar must be multified at 1 Yes 2 No Director Parkton Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21120 United States 825 Miller Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Btack, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iten any injury or other traumatic event, the Medical Exambres once. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married White Specify: 1 Tyes 2 XNo Specify: Baltimore, Maryland 21215-0036 Š 3€ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Edna Thorpe Archie Ratcliffe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 825 Miller Road, Parkton, Maryland 21120 Mrs. Lois Miller (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 08/28/2008 Sykesville, Maryland Lakeview Cemeterv ☐ Departion 5 ☐ Other (Specify) of Euneral Service Licensee 22. Name and Address of Facility 21. Signature Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) UREMI **Physician** /Medical Due to (or as a consequence of) Examiner CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner MALNOUNISHMEN The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760, IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 20 No 1 ☐ Yes To the Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check onl one Other: Hospital: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA P this 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: After 5 Pending investigation 1-Natural 1 🗌 Yes 2 No death. 2 Accident Director 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by determined 4 Homicide hours after 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier icai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 To the I 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier りみチナ Religiodo EMGE PARKVILLEMO 21234 30. Name and address of erson who completed cause of death (Item 23a) (Type, Pript)

State Registrar

31. Date filed (Month, Day, Year) AUG 2 8 2008

FORNMAO



			For State Registrar	ate of Maryland / Dep <i>Ce</i>	rtificate of			Reg. No.	008	27749	
			1. Decedent's Name (First, Middle, Last)			2. Date of Dea	ath Day	Year	3. Time of Death		
Physician /Medical Examiner			Viola	Willia	Williams		22	2008	18:10 M		
			4a. Facility Name (If not institution, give street	4b. City, Town, o	WIIIIams (4b. City, Town, or Location of Death			4c. County of Death			
			6511 Fairmont Ave	ltimore				_			
	Funeral		Social Security Number 6. Sex	7. Age (In yrs. last birthday,		If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da 05 21	h v. Year)	9. Birthp	place (State or Foreign	
	Director		219-02-9345	72 Yrs.	Wieriting	Trodic IIII	05 21	36		naica	
	D .		Usual Residence of Decedent							Od In old - City Limite	
	rylar	_	10a. State 10b. County	10c. City, Town or Lo					'	0d. Inside City Limits	
	Ba-f	Director	MD NA	Ba	ltimore					1 XYes 2 No	
	or 28	Sire	10e. Street and Number		10f. Zip Code				of What Cour	•	
	I within 72 hours after death with the Maryland jiene. I then "natural", or items 23a or 28a-f show the Mozical Examinat must be coffiled at	la l	6511 Fairmont Ave		-	21215			J.S.A.	•	
	ems ems	Funeral	11. Marital Status 12. W	as Decedent Ever in U.S. 13. med Forces?	Was Decedent of H	lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No Rican, etc.)	- 14.	Race - Americ Black, White, e		
9	or it		1 ☐ Never Married 2 ☐ Married 1	∏Yes 2 TvNo	1 □Yes 2 No	Specify:		i		lack	
8	ours	Completed by	3 Widowed 4 □ Divorced Ÿe	ear or Dates:	7.						
5-	72 h	ete	15. Decedent's Education (Specify only highest grade com	pleted) I (Give	edent's Usual Occup kind of work done	durina most of work	ing 1	16b. Kind	of Business/Inc	dustry	
21	within iene. than "	ם		ollege (1-4or 5+)	DO NOT use retired	d)				•	
2	al Hygier other th	S	12th grade	na	LPN		45° + 14° + 4°		sing F	iome	
pu	be filed Ital Hyg Id other event,	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name			rname)		
yla		ပ္	Uriah Wright				le Wright				
Maryland 21215-0036	S D E E		19a. Informant's Name/Relationship (Type. Pi	· .			ural Route Number, City or Town, State, Zip Code)				
≥,	s 1 and 2 of Health a item 27 is other trai		Winston Williams-							Md 21207	
ore	ges 1 and it of Healt if item 2 or other		20a, Method of Disposition	20b. Place of Disponentery, cre	osition (Name of matory or other plac	ce)	Date	20c. Locat	ion - City or To	wn, State	
Ĕ	Pages nent of I ant: If ite		Unit Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	Wood	lawn	8/27	/08	Balt	imore	Co, Md	
Baltimore,	# もモデー		21. Signature of Funeral Service Licensee	M M	2. Name and Addre					,	
Ö	permi Depar Impor any ir	9	Demala U. X	MANA 4	300 Waba	ash Ave,	Balti	more	, Md	21215	
			23a. Par 1. Enter the disease, or complication	s that caused the death. Do not en					-	Approximate Interval Between	
-	Physician		s ock, or heart failure. List only one cau			· Cardia		. 1 .	000	Onset and Death	
-	/Medical		Imprediate Cause (Final disease or condition resulting in death) a. How to go a consequence of):								
	Examiner			Die to (of as a consequence of).							
		ē	Sequentially list conditions.	Due to (or as a consequence of).							
1 .	nsit n	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
1	execu and al-tra	Xai	that initiated events c. resulting in death) Last Due to (or as a consequence of):								
68760,	tificate be executed g physician and as the burial-transit	E E									
387	icate phys the	edical	d								
			IF FEMALE: 23c. If	ves. outcome of pregnancy				224	22d Date of delivery		
23b. Was decedent pregnant in the past 12 months?						230	23d. Date of delivery Month Day Year				
o.	the the	ysic		Unknown	Other (specify) _						
P.0	that the de ned by the a detached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					23e. Did tobacco use contribute to the cause of death?			
Division of Vital Records,	signe be d	þ						1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ✔ Unknown			
0.5	w requir been s should	Completed						The second representation of the second repre			
ec	e law has b je 2 sl	현					autor	autopsy prior to o		opsy findings available empletion of cause of	
=		S I					performed 1 ☐ Yes 2 🗶		? death? No 1 □Yes 2 □No		
/ita	iclan: The certificate ector, pag	Be (25. Was case referred to medical examiner?			26. Place of Deat	th (Check only o	ne)			
_	Physiclan: this certific ral director,		Hospital: 1 patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
0	nera	Ë	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 1 Natural 5 Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Work?								
<u>.</u>	Attending r death. sctor: After by the funer	atic	1 XNatural 5 ☐ Pending (Month, Day, rear) Injury Work? 2 ☐ Accident investigation M 1 ☐ Yes 2 ☐ No								
<u> </u>	ar de recto	tific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28	 e. Place of Injury - At home, farm, st building, etc. (Specify) 	reet, factory, office	ce 28f. Location (Street and Number or Rural Route Number, City or Town, State)					
25. Was case referred to medical examiner? Total Part Part							3.9 3. 13, 3.0.0)				
	29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Check only one 29m Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
	n 24 n 24 ne Fi	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year							o are cause(s)		
	To the within 2 To the comple	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo						igned (Month,	Day, Year)		
			Library Ht. Man N-	v.t.	1018	667		Duck	5/21.	2.008	
	10		30. Name and address of person who comple	led cause of death (Item 23a) (Type	, Print)	E E 1		Tryu	2,26	0	
	le		Philip Militaly MI	6 Trimble Hill	CILLAthou	villo Md	2109	7			
	Sta	te	31. Date filed (Month, Day, Year)	52. Registrar's Signature	AND I	1					
	Registr		AUG 2 8 2008	Cours of 19	1000						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 2008 8:00 PM Martha C. Wentzler /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Timonium Baltimore 5. Social Security Number 8. Date of Birth (Month, Pay 3ear) 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** Months Days Hours Min. Mary Tand 1 □ M 2 🗙 F 213-03-9526 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Opertment of Health and Mental Hygelen. Internative if them 27 is marked other than "natural" or items 23a or 28a-1 show important; if them 27 is marked other than "natural" or items 23a or 28a-1 show any Injury or other traumatic event, the "Morical Examinar must be notified at 1 ☐ Yes 2 No Director Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21234 U.S.A. 2806 Maple Avenue Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 📉 No Specify: Specify: þ White 3 X Widowed 4 ☐ Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Home Maker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Charles Link Antionette Griegoleit 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Mark Raebiger - Nephew 2806 Maple Avenue Baltimore, Maryland 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Hilltop Service Corporation 08/26/2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service ticensee 22. Name and Address of Facility 5305 Harford Road Chales Baltimore, Maryland 21214 Leonard J. Ruck, Inc. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only the cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 mont Month Year 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Tes 2 No 3 Probably 4 Inknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 1 □ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Sursing Home 5 Residence 6 Other (Specify) 27. Minute of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending 24 hours after death. 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide e wing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 12 et l'ong Physician: To the best of my knowledge, death occurred at the time, date and place, and une to the cause(s) and mainten as sales.
2 are cal Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

P.O. Box 68760,

MARTHA WENTZLER

of Vital

Division

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year) 8.26.08

and manner stated.

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

EDDIE NAKHUDA, M.D.

AUG 2 8 2008

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** /Medical Richard I. Walters 2008 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Stella Maris Hospice Dulaney Valley
If Under 1 Year | If Under 24 Hrs. Baltimore Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Months 1√2 M 2□ F Days Hours 85 Director 214-18-7521 01-05-1923 Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 🕅 No Director Maryland Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1921 Jasmine Road 21222 Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1√2Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 21215-0036 1 ☐ Yes 2√No Specify: \$ 3 ₩ Widowed 4 □ Divorced Specify: White Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Parts Attendant Automotive Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 1 and 2 should be fi Health and Mental I ဂ္ Charles R. Walters Ola Minton 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2. Department of Health a Important: If Item 27 is (Daughter) 7878 Mansion Crossing Pasadena Maryland 21122 Ola F. Coursey 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp.08-26-2008 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk Inc. 7922 Wise Avenue Dundalk, Maryland 21222 231 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CONGESTIVE HEART FAILURE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Exami sician and burial-trans Due to (or as a consequence of): 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy Vital 1 □ Yes 1 ☐ Yes 2 ☐ No 2 X No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: $4 \square$ Nursing Home $5 \square$ Residence $6 X \bigcirc$ Other (Specify) **HOSPICE** 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No the 1 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated. 29c. License number 29b. Signature a d title of certifie 29d, Date signed (Month, Day, Year) 2 Nd 2008 Daust 3 30. Name and address of person who completed cause of death (Item 33a) (Type, Print) 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 DR. ERNESTINE WRIGHT 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

To the 1

State Registrar

29b. Signature and title of certifier

Donna M. Vincenti, MD

nu

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

August 23, 2008

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Day 2008^{eai} August 26, Рм Mehdi Larizadeh Yeganeh 7:55 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Care Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Aug. 24 | Aug. 24 | Aug. 24 | 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral Year. 1 □ M 2 □ F 215-40-2452 83 Yrs. 1925Director Iran Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Marylannent of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, It is Madical Even har cust by notified an any Injury or other traumatic event, It is Madical Even har cust by notified at once. **Funeral Director** 1 ☐Yes 2 ☑ No MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 223 Purlington Road 21093 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimóre, Maryland 21215-0036 1 □Yes 2 No Completed by Specify. 3 X Widowed 4 □ Divorced white 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Psychiatrist Medical unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) Be 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael L. Yeganeh 814 Duncan Place; Leesburg, VA 20175 son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 8/28/08 Towson, MD 21. Signature of Furer I S 22, Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Entertitle disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) seass / /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): burial-transi Division of Vital Records, P.O. Box 68760_{r} Due to (or as a consequence of): Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 □Yes 2 □ No Month Day Year 5 ☐ Other (specify) is certificate has been signed by the director, page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsy this certificate 2 No 2 □ No 1 ☐ Yes 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 ☑ 🗖 🗸 o Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Space 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural To the Hospital or Attendl within 24 hours after death. To the Funeral Director: A 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number no 30. Name and address of person who completed cause of death frem 23a) (Type, Print) Charles St. Bolto. Md 701

Registrar

State

31. Date filed (Month, Day,

Year)

AUG

32. Refistrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year Day Month **Physician** 11:10 a^M Michael L. Acuff August 11, 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Washington Adventist Hospital Takoma Park Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 € M 2 □ F Director 55 June 4, 1953 Tennessee 213-66-4601 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County r 28a-f show inotified at show 1 ☐Yes 2 🗓 No Director Maryland Silver Spring Montgomery 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or USA 13304 Hathaway Drive 20906 Funeral ir than "natural", or items The Medical Examiner on 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant; If Item 27 Is marked other than "natural", or Ite 1 ∏Yes 2 ☑ If Yes, Give Year or Dates: 1 v Never Married 2 ☐ Married 2 Maryland 21215-0036 White 1 ☐ Yes 25 No Specify Specify: ፩ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Roofer Construction 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be John L. Acuff Margaret A. Trussell ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and Department of Health Important; If Item 27 any injury or other tronce. Margaret A. Acuff/Mother 13304 Hathaway Drive, Silver Spring, mD 20906 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 13 Norbeck Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) Olney, MD ²² Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, 21. Signatu 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on such line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** ULTIPLE ORGAN DYSFUNCTION disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** SEPTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last law requires that the death certificate be executed and burlal-trar Due to (or as a consequence of) Box 68760, attending physician for use as the burla Physician/Medical IF FEMALE yes, outcome of pregnancy
Live birth 2 Fetal death
Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) signed by the a P.O. 9 Unknown Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Was a... autopsy performed? Ves 2 1 No has certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 X No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) completely filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i or Attending Fafter death. After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) within 2 the 29c. License number 29b. Signature and title of ertifier 29d. Date signed (Month, Day, Year) ٥ 66771 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ang Galena-Santiago, 7600 Carroll Avenue, Takoma Park, MD 20912 MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State AUG 13 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Ali Majid Abdus Samad 22:46 2008 Aua 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Prince Georges Prince Georges Hospital Cheverly If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, Voar Hours 60 Months Days 1 X M 2 □ F 051-30-2233 22.1947 New York Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County Mitchellville 1 ☐ Yes 2 ☑ No Prince Georges Md. 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 20721 1114 Winding Brook Ct. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 ☐ No 14. Race - American Indian, 11. Marital Status Affiled 1 of 2 ☐ No
1 XYes 2 ☐ No
If Yes, Give
Year or Dates Unknown 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Medical/College Professor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) William Holiday Rosalie Stuckey Sveda 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20721 19a. Informant's Name/Relationship (Type. Print) Hasiba N. Ali/ wife 1114 Winding Brook Ct. Mitchellville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 Removal from State Maryland National 8/13/08 Laurel, Md. 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Universal Mortuary Am Wart 411 Kennedy St., N.W. Washington, DC20011 23a. Part 1. Ent. If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Fatal Cardiac Arrthymia hour Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Unarrying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Vear 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Probably 4 N Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 🛭 No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner**

permit. Pages 1 and 3 Department of Health Important: If Item 27 any injury or other tr. once.

27

Physician

Examiner

Funeral

Director

28a-f show

death with

72 hours after

filed within 7 I Hygiene.

12 should be filed with and Mental Hygier 7 is marked other the

Maryland 21215-0036

Baltimore,

Director

Funeral

2

Completed

Be

၉

7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Examiner must be notified at

/Medical

burial-tran physician the as attending nse s for ed by the a signed by t page funeral director, this After To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A filled in by the

requires that the death certificate be executed

Box 68760.

P.O.

Division of Vital Records,

Physician:

Attending

death.

Examine Physician/Medical 2 Completed Be Certification: To

IF FEMALE: 27. Manner of Death 1 Natural 2 Accident

disease or condition resulting in death) 1 Yes 2 No

3 Suicide

29a, Certifier

4 Homicide

(Check only one)

23b. Was decedent pregnant

5 Pending investigation

28a. Date of Injury (Month, Day, Year) 28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Excertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

DC 20037

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and litle of certifier

6 ☐ Could not be

determined

29c. License number

29d. Date signed (Month, Day, Year,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Ave. 2150 Pennsylvani Washington, Amy Hall-Woods

State Registrar

Medical

31. Date filed (Month, Day, Year) AUG 1 4

27756

Physician
/Medica
Examine

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f show any liqury or other traumatic event, I'm Medical Evantive rout be notified at any liqury or other traumatic event, I'm Medical Evantive rout be notified at angles.

Baltimore, Maryland 21215-0036

Physician) /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Registrar

	- State Registrar			Cer	tificate of	Death	1		Reg. No	K U	00	611	JU
	1. Decedent's Name (First, Middl	e, Last)						2. Date of De			Voor	3. Time of D	eath
ın	GEORGE	EA	RĽ	AUS	STIN			AUGUS	T 12	200)8 ^{ear}	3:44	Ам
al er	4a. Facility Name (If not institution	n, give street and nu	mber)		4b. City, Town,	or Location	of Death		40	. County	of Death		
G1	PRINCE GEORG				CHEY	ERLY			I	PRIN	CE GE	EORGE'S	
	5. Social Security Number	6. Sex	7. Age (In yrs. la	st birthday)	If Under 1 Year		r 24 Hrs.	8. Date of Bi					Foreian
	231-03-3447	1 X M 2□ F		Yrs.	Months Days	Hours	Min.	DEC. 2	ay, Year,	919	VTR	place (State or intry) GINIA	
	Usual Residence of Decedent		88				1	DEC. Z.	J 1.	11)	VIII	JINIII	
	10a. State 10b. County		10c. City,	Town or Loc	ation							10d. Inside City	Limits
ō					_						1	X⊟Yes 2	2 No
ect	MD PRINCI 10e. Street and Number	E GEORGE'S	5 L <i>E</i>	NDOVE	10f. Zip Code				10a Ci	itizen of	What Cou	intry?	
ä					Tot. Zip code	20705			rog. O	USA		y.	
ra	6903 KENTTOWN I			1		20785							
Ë	11. Marital Status	Armed F		. 13. V	Vas Decedent of Yes, specify Cu	Hispanic O ban, Mexica	rigin? (Sp an, Puerto	ecity Yes or No Rican, etc.)	0-		ce - Amer ck, White,	ican Indian, , etc.	
Ϋ́	1 Never Married 2 Mar	If Yes, G	2∭∑No ive	1	□Yes 2X No	Specify	<i>r</i> :			Specif	v: BL	ACK	
Be Completed by Funeral Director	3 Widowed 4 Divorced		Dates:										
lete	15. Deceder (Specify only highe	nt's Education est grade completed,		(Give F	lent's Usual Occu kind of work done	during mo	st of work	ing	16b. F	(ind of B	usiness/lr	ndustry	
ш	Elementary/Secondary (0-12)	College (1-4or 5+)		O NOT use retir	9d)			DD.	IVAT	E		
ပ္ပ	12th			TRUCK	DRIVER		C	(E) . A () I II					
Be	17. Father's Name (First, Middle,	Last)						e (First, Middle		n Surnar	ne)		
ပ္	WILLIE AUSTIN					C/A	AKKIE	AUSTI	N				
	19a. Informant's Name/Relations			19b. Mailin	g Address (Stree	t and Numi	ber or Rur	ral Route Numi	ber, City	or Town	State, Z	ip Code)	
	VIOLEAN AUSTI	N/WIFE		6903	KENTTOW	N DKT	VE LA	NDOVEK	, MAK	LLAN	ע ע	703	
	20a. Method of Disposition			ace of Dispos	sition (Name of natory or other pl	ace)	[Date	20c. L	ocetion	- City or T	own, State	
	1 ☑ Burial 2 ☐ Ofernation 4 ☐ Donation 5 ☐ Other (5				TION CEM		8/1	6/2008	CLI	NOTN	, MARY	YLAND	
	21 Signature of Funeral Service		1	22	. Name and Add	ess of Faci	lity	J. B.	JENE	CINS	FUNI	ERAL HON	ME.
/	- W/Z				7474 LAN	DOVER	ROA	D LANDO	VER.	MAR	YT.ANI	20785	
	23a. Part 1. Enter the disease, o	r complications that	caused the death.							,		Approximate	
	shock, or heart failure. List Immediate Cause (Final	only one cause on	each line.	_								Interval Betw Onset and D	
	disease or condition resulting in death)	_ a Co	preno	80.4B	m 925	eas	_0_						
	, rooming in additing	Due to	(or as a conseque	ence of):									
_	Sequentially list conditions, if any, leading to immediate	b											
ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conseque	ence of):									
кап	that initiated events resulting in death) Last	C	(or as a conseque		·								
Ē		Bue to	(or as a conseque	erice ory.									
n/Medical Examiner		d									-		
Me	IF FEMALE:												
an/	23b. Was decedent pregnant		itcome of pregnar birth 2☐Fetal		Ectopic pregna	ncy					ate of deli	*	ear
sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pre	gnant at time of de	ath 5	Other (specify)			<u></u>		IV	lonth	Day Y	ear
Be Completed by Physician	9 Unknown						_						
by F	Part II. Other significant conditi	ons contributing to	death but not resul	ting in the ur	nderlying cause g	iven in Part	1.	23e. Did	tobacco	use cor		the cause of de	
ba								1 🗆	Yes 2	2 X No	3☐ Pr	obably 4 🗌 U	nknown
olet								24a. Wa	s en	24b.		topsy findings a	
E		,,,,,						auto	opsy formed? 2 AN		death?	completion of ca	ause of
ŭ	25. Was case referred to medica	N I								lo	1 □ Yes	2 XNo	
	examiner?	Hospital:	· · · · · · · · · · · · · · · · · · ·			thor:		th (Check only					
٠ <u>۲</u>	1 ☐ Yes 2 🕱 No 27. Manner of Death	28a. Date		R/Outpatien 28b. Time of	I 3 L DOA	4 🗆 1	Nursing Ho	ome 5 Res				cify)	
ion	1 Natural 5 ☐ Pendi	ng (Mo	nth, Day, Year)	Injury	W	ork? □Yes 2[Zou. Describe	2 110 W 111j	ary occu	iicu		
icat	2 Accident Invest 3 Suicide 6 Could	not be					7140	OOK Lanation	(5)			- I D - A Maria	
Ħ	4 ☐ Homicide deterr	nined 28e. Place	e of Injury - At hor ling, etc. <i>(Specify</i>)	et, lactory, office	•		City or To	own, Sta	te)	iber or Hu	ıral Route Numl	oer,
Medical Certification: To	On Consider			lad :						()			
ical	(Check only 2 Medica	ng Physician: To the Examiner: On the	basis of examinat)
led	one)		nner stated.					1			- al 28.8 ***	h David Va	
-	29b. Signature and title of certific	110				nse number						h, Day, Year)	
	Pom.orue	_((000	>59	181		81	14	150	9	
	30. Name and address of person											0.07.5	
	Mukemil A	rodella	1mD	6005	5 LANDOV	ER RO	AD SU	UITE 3	CHEV	/ERL	Y,MD	20785	
te	31. Date filed (Month, Day, Year,	32.	Registrar's Signat	ye									
ar	AUG 1 5 2008	Kenny	K A	Select of the se									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Day 6:30PM Carol V. Bailey Aug. 02, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Bel Pre Nursing Home Montgomery Silver Spring 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2¥3¥ Months Days Hours Min 60 rs. Director 579-64-4498 09/19/1947 Wash., D.C. Usual Residence of Deceden should be filed within 72 hours after death with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at XX Yes 2 □ No Director MD Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2601 Bel Pre Road 20906 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specity Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Race - American Indian. Black, White, etc. Amied 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify Specify: Black 3 Widowed 4 Divorced "natural" the Medical Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12th Cosmetologist Private Industry of Health and Mental Hygis fitem 27 is marked other ir other traumatic event, tt 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clifford Bailey Bernice Simmons P 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If item 27 is n any Injury or other traun Bernice Williams/Mother 1845 Tanow P1. District Heights, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State Riverdale Crematory Aug. 14,2008 Riverdale, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Latney's Funeral Home 22. Name and Address of Facility 3831 Georgia Ave., NW Washington, DC 20011 23a. Part1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Breast Cancer disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Unice to a many that initiated events resulting in death), and Due to (or as a consequence of) Examine law requires that the death certificate be executed burial-trar resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician Physician/Medical the. use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy ło in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 9☐Unknown 5 Other (specify) detached the 9 Unknown sate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy or Attending Physician: The perform certificate 2 XX 1☐ Yes funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Other: Wursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 ☐ Pending investigation (Month, Day Year) death. 1 ☐ Yes 2 ☐ No the within 24 hours after death To the Funeral Director; 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) couse triltan August 11, 2008 D 56691 30. Name and addless of person who completed cause of death (Item 23a) (Type, Print) Ghousia Sultanna, M.D., PA. 12107 Heritage Park Circle Silver Spring MD 20906 31. Date filed (Month, Day, Year) 3 Registrar's Signature State AUG 14 Registrar

0			_ 101	artment of Health and Mental Hy rtificate of Death	ygiene Reg. No. 2008 27758
	Physicia /Medic		1. Decedent's Name (First, Middle, Last) Howard Lee BLUMENT!	AAL 2. Date of D. Month August	Day Year
may J	Examin		4a. Facility Name (If not institution, give street and number) Layhill Center 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	4b. City, Town, or Location of Death Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Bi Months Days Hours Min. (Month, D	4c. County of Death Montgomery inth 9. Birthplace (State or Foreign
	Director		577-38-6394 1 (M 2 □ F 86 Yrs. Usual Residence of Decedent		2, 1921 Maryland 10d. Inside City Limits
	hours after death with the Maryland tural", or items 23a or 28a-f show at Eraninan must be notitled at	rector	10a. State 10b. County 10c. City, Town or Lo Washing		1 M Yes 2 No 10g. Citizen of What Country?
	death with ms 23a or	Funeral Director	3700 N. Capitol Street., NW/ USSAH 750		United States
215-0036	nours after ural", or ite	by	1 XNever Married 2 Married 1 XNYes 2 No If Yes, Give Year or Dates: WW II	1 □Yes 2 🗖 No Specify:	Specify: white
-61212	l within 72 jiene. r than "na the Medic	Completed	(Specify only highest grade completed) (Give	ident's Usual Occupation kind of work done during most of working DO NOT use retired)	Home Furnishings
Maryland	e filed al Hy I othe vent,	To Be C	17. Father's Name (First, Middle, Last) Benjamin Blumenthal	18. Mother's Name (First, Middl Alice Weiner	le, Maiden Surname)
	ages 1 and 2 should b int of Health and Ment t: If item 27 is marked y or other traumatic e		Elinor Kinland, Niece 4121	Springview Drive, Jeffe	
altımore,	4 5 E E		4 Donation 5 Other (Specify) Soldier's	position (Name of matory or other place) 08/14/08 Home National Cemetery 2 Name and Address of Facility	Washington, DC
eg R	permit. Departit Import. any Inj.	0 5		2. Name and Address of Facility Orchinsky Hebrew Funeral 54 Carroll St., NW, Wash Iter the mode of dying, such as cardiac or respiratory	ington, DC 20012
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death) Atrial Fibrillati Due to (or as a consequence of):	on	Onset and Death
		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Universitying Cause (Disease or injury		
8760,	cate be executed bhysician and the burial-transit	dical Exa	that initiated events resulting in death) Last C. Due to (or as a consequence of):		
. Box 6	death certifi e attending ; id for use as	Physician/Med		□ Ectopic pregnancy □ Other (specify)	23d. Date of delivery Month Day Year
rds, P.	law requires that the dias been signed by the 2 should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the u	and and an an an an an an an an an an an an an	d tobacco use contribute to the cause of death?
<u> </u>	The lar ate has page 2	Completed	Clostridium Difficile Colitis Pulmonary Embolism	24a. Wa aui pei 1	topsy prior to completion of cause of death?
ο τ Vita	Attending Physician: The r death. ector: After this certificate h ector: After this certificate hby the funeral director, page	Be	25. Was case referred to medical examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatien 27. Manner of Death 28a. Date of Injury 28b. Time of the control of the contro		
Division of	al or Attendin s after death. al Director: Af ed in by the fur	Certification: To	1 Natural 5 Pending (Month, Day, Year) Injury 2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	M 1 ☐ Yes 2 ☐ No treet, factory, office 28f. Location	L (Street and Number or Rural Route Number, own, State)
	To the Hospital or A within 24 hours after To the Funeral Dire	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) Certifying Physician: To the best of my knowledge, dea (Check only one) A certifier (Check only one)		
	S +1	M	29b. Signature and title observirier MACO M. D.	29c. License number D 0064208	29d. Date signed (Month, Day, Year) August 11, 2008
7			30. Name and address of person who completed cause of death (Item 23a) (Type Saadia Husain, M.D., 4409 East-West 131. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Highway, Riverdale, MD	20737
	Sta Registi		31. Date filed (Month, Day, Year) AUG 1 3 2008 Registrar's Signature	We	

DHMH 17 Rev 1/2001

Registrar

AUG 1 5 2008

EDDI

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Anita P. Battese 5:45 P M Aug 10, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 M 2 XX Months Days Hours Min. Director 578 40 0751 75 Dec 25, 1932 Washington DC Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.

ther than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Examinary wet by nothled at 1 ☐ Yes 2 ☐ No Director Maryland Calvert Huntington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3040 Richfield Road 20639 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 □Yes 🏋 🟋 No Specify Specify: Asian δ ₩Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) Pages 1 end 2 should be filed will
thent of Health and Mental Hygien
tant: If item 27 is marked other th
jury or other traumatic event, Ibu. Secretary Federal Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mateo Perez Consuelo De La Pena ပို 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Green (Son) 3040 Richfield Road, Huntingtown, MD 20a. Method of Disposition
1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 15, Dat 2008 20c. Location - City or Town, State permit. Pages
Department o
Important: If
any Injury or
once. Clinton, Maryland Resurrection Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Fuperal Service Licenses M01533 Alexandria Ferry Road, Clinton, MD 20735 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or shock, or heart failure. List complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one call e on each line. Immediate Cause (Final Physician umona disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed the burial-tra Due to (or as a consequence of): Box 68760, physician Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 5 ☐ Other (specify) P.0. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>م</u> 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe Physician: The 2 No 2 🗆 No 1 □ Yes 1 🗌 Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) After th funeral 27. Mann of Death 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Hospital or Attending 1 Natural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 1 28f. Location (Street and Number or Rural Route Number, City or Town, State) Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Medical 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier License number of death (Item 23a) (Type, Print) Name and addre of person who comi alle Ohn 31. Date filed (Month, Day, State Year **AUG 14** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 2002M ISELLO 08 **Physician** RIS /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner ANNE ARUNDEL ANNAPOLIS ANNE ARUNDEL MEDICAL CENTER 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days 1 □ M 2 💢 F NOVEMBER 8, 1929 WASHINGTON, D.C. Director 579-36-2702 78 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland 10a. State 10b. County an "natural", or items 23a or 28a-f show Medical Examiner must be notified at 1 ☐ Yes 2X No Directo QUEEN ANNE'S STEVENSVILLE MARYLAND 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 21666 318 WILLIAM WAY Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: WHITE Maryland 21215-0036 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. other than " Elementary/Secondary (0-12) College (1-4or 5+) OWN HOME the HOMEMAKER 12 permit. Pages 1 and 2 should be filed Department of Health and Mental Hyg Important: If item 27 is marked other any Injury or other traumatic event, it 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ELIZABETH CLEMET JAMES ROBERT NASH 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 318 WILLIAM WAY, STEVENSVILLE, MARYLAND 21666 CHRISTOPHER BELLO/SON Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition AUGUST 14 1 ☐ Burial 2 XCremation 3 ☐ Removal State STEVENSVILLE, MARYLAND CHESAPEAKE CREMATION 2008 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Serv Licensee FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 cause the death. Do not enter the mode of dying, such as cardiac, it respiratory arrest each line. Approximate Interval Between Opset and Death 23a, Part1, Er shock, or heart failu Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome pf pregnancy 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy 1 ☐Live birth Year in the past 12 months? 1 ☐ Yes 2 Z No 4☐Pregnant at time of death 5 Other (specify) cate has been signed by the page 2 should be detached 9☐Unknown 9 Unknow 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy performed /es 2 🔾 Yes the Hospital or Attending Physician; ours after death.

eral Director: After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: Hospital: 1 Anpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3□ DOA 1 ☐ Yes P 28d. Describe how injury occurred Date of Injury (Month, Day 28b. Time of 27. Manner of Death Certification: 1X Natural 5 ☐ Pending 1 □ Yes 2 □ No investigation 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated To the within 2 29c. License number 29b. Signature and title of certifier

State Registrar

completed ause of death (Item 23a) (Type, Print) DATENSE HIGHWAY

08-06274 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 5 per fn. 2893,07/23/09dib Health and Mental Hygiene Certificate of Death Andre J. Baker 1- For State Rea No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day August 16, 2008 0732 hrs **Medical Examiner** Andre Ι. Raker 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death c. County of Death Prince George's **Doctors Community Hospital** Lanham g. Birthplace (State or Foreign If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) If Under 1 Year 7. Age (In vrs. last birthday) **Funeral** 578 Security Number Country) Washington, DC Davs Hours Min Months Jan 19, 1959 Director 49 1 X M Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No District of Columbia Washington 28a-f shov important: If item 27 is marked other than "natural", or items 23a or 28a-f sho mary or other traumatic event, the Medica. Examin<u>er must be notified at once,</u> Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20019 United States 5052 Central Avenue, Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? Married Never Married 2 Yes 1 Yes 2 X No specify: If Yes, Give Year Specify: Black 3 Widowed 4 X Divorced ş 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) it. Pages 1 and 2 should be filed within 72 hou tment of Health and Mental Hygiene. Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Unemployed 12 years 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Geneva Proctor Joseph W. Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Deborah A. Baker - Sister 5052 Central Avenue, SE Washington, DC 20019 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition Baltimore, crematory or other place) X_{Burial} Removal from State Mount Olivet Cemetery Aug 21, 2008 Washington, DC Oth permit. Signature of Funeral Serv ce License 22. Name and Address of Facility Stewart Funeral Home, Inc. 4001 Benning Road, NE Washington, DC 20019 Approximate Interval art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Between Onset and ailure. List only one cause on each line /Medical Heroin & cocaine intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): transit The law requires that the death certificate be executed and AMENDED 23a, Pli, 27, 28a-f, perME, g88 28/29/08 TT Physician/Medical X UNPENDED the attending physician ed for use as the burial -Division of Vital Records, P.O. Box 68760, IF FEMALE: 23d. Date of delivery 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Day 3 Ectopic pregnancy Month Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown g Unknown detached 23e. Did tobacco use contribute to the cause of death? signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 V No 3 Probably 4 Unknown Sepsis, cirrhosis, atheroscerotic cardiovascular Completed 24a. Was an 24b. Were autopsy findings available peen disease autopsy prior to completion of cause of After this certificate has performed? death? 1 V Yes 2 No Yes 2 26.Place of Death (Check only one the Hospital or Attending Physician: 25. Was case referred to medica funeral director, Be examiner? Hospital: 1 Inpatient Other₄ ER/Outpatient DOA Nursing Home 5 Residence 6 Other ဥ 1 Yes 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred 27 Manner of Death 28a. Date of Injury Certification: Natural Yes 2X No unk within 24 hours after death. To the Funeral Director: Pending the Fnd 8/15/08 Fnd 9:00pm 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) $5052\ Central\ Ave.$ filled in by 28e. Place of Injury - At home, farm, street, factory, office found at residence office building, etc 3 Could not be Suicide

ORIGINAL

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

(Specify)

30. Name and address of person who complete cruse of death Item 23a)

manner stated

Deputy Chief Medical Examiner

32. Regiment's Sig

4

completely within 24

Medical

State

Homicide 29a. Certifier 1

29b. Signature and title of certifier

Mary G. Ripple MÓ

29d. Date signed (Month, Day, Year)

August 17, 2008

Washington, DC

			1 _ State	aryland / Dep	partment of H			iene _{eg. No.} 2 () () {	27763
44			Registrar 1. Decedent's Name (First, Middle, Last)		Timeate of i		2. Date of Deat	h	3. Time of Death
	Physicia		Robert Lloyd Carmack,	Sr.			Month	Day Year 13, 2008	8:07 a M
0	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death	11111111111	4c. County of Dea	ath
ر السائد			505 High Acre Drive			inster		Carro	
	Funeral		5. Social Security Number 6. Sex 7. Ag 129 − 18 − 8448 1. M M 2 □ F	ge (In yrs. last birthda) 84 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Jan 1, 1	Year) 9. Bi	rthplace (State or Foreign country) nsylvania
	Director		Usual Residence of Decedent	04 110			han I, I	924 [61	nsyrvania
	yland Iow at		10a. State 10b. County	10c. City, Town or I					10d. Inside City Limits
	a-f sh	ctor	Maryland Carroll		Wes	stminster	<u> </u>		1 □Yes 2X No
	J within 72 hours after death with the Maryland jaene. I than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	Director	10e. Street and Number 505 High Acre Drive		10f. Zip Code	21157	10	og. Citizen of What C USA	Country?
	ms 2;	Funeral	11. Mantal Status 12. Was Decedent	Ever in U.S. 13	B. Was Decedent of H If Yes, specify Cuba	lispanic Origin? (Sp	ecify Yes or No-	14. Race - Am	
30	s after ", or ite	by Fu	Armed Forces? 1 □ Never Married 2 □ Married 1 ★ Yes 2 □ If Yes, Give Year or Dates:	No	1 ☐ Yes 2 X No	Specify:	riicari, etc.)	Black, Wh	white
15-0036	hour atural	ed b	15. Decedent's Education	16a. Dec	edent's Usual Occup	ation	1	 16b. Kind of Busines	s/Industry
15	in 72 in "na Medir	Completed	(Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or	life.	ve kind of work done . DO NOT use retired	during most of work d)	king	State of	·
717	d with giene er tha , the l	E O	10		rpenter F	-		Marylan	d
2	be filed tal Hygi d other event, tl	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, N Amsley	Maiden Surname)	
<u> </u>	Men Men Marke Marke	은	Arthur Carmack	100.00	"			0% - T 00-t-	7.0.13
Maryland 2	ages 1 and 2 should be filed vent of Health and Mental Hygiet. If Item 27 is marked other? y or other traumatic event, the		19a. Informant's Name/Relationship (Type. Print) Charles A. Carmack, son		559 Pine R			, City or Town, State, DE 19975	Zip Gode)
ē,	s 1 and 2 of Health a item 27 is other trai		20a. Method of Disposition		position (Name of rematory or other place	ce)	Date	20c. Location - City of	or Town, State
Ē	Pages nent of h ant: If ite ury or o		1 ☐ Burial 2 MCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (<i>Specify</i>)		Cremator		/2008	Winfield,	MD
Baltimore,	permit. Page Department I Important: If any Injury or		21. Signature of Funeral Service Licensee	9	22. Name and Addre	ss of Facility My Street, W	ers-Durb Jestminst	oraw Fune er, MD 21	ral Home 157
	- 11		23a. Part). Enter the disease, or complications that cause	d the death. Do not e	enter the mode of dyir	ng, such as cardiac	or respiratory arre	est,	Approximate Interval Between
	Physician	Ø 1	shock, or heart failure. List only one cause on each in Immediate Cause (Final	4.0	ell lu	00 00	ncer		Onset and Death
1	/Medical		resulting in death)	a consequence of):	EII IW	ng ca	M CC1		a months
	Examiner		Sequentially list conditions b.			1038			
	be sit	Examiner	Sequentially list conditions, if try local sequentially list conditions, cause. Enter Underlying Cause (Disease or injury	a conse uence of:					
	and I-trans	хаш	that initiated events C.	a consequence of):					
8760,	cate be executed physician and the burial-transit								
687	ficate physis the	edical	d						
ROX	leath certifica attending pt I for use as t	n/M	IF FEMALE: 23c. If yes, outcome 23b. Was decedent pregnant					23d. Date of d	elivery
	death	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 1 ☐ Helenown		3 □Ectopic pregnanc; 5 □ Other <i>(specify)</i> _	у		Month	Day Year
J.	at the de by the	hys	9 LI Unknown				1 00 01111		
	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		Part II. Other significant conditions contributing to death the Pulmonary - Fibros		underlying cause giv	en in Part I.	23e. Did tol		to the cause of death? Probably 4 Unknown
Vital Records,	requ	Completed by							
ě	siclan: The law certificate has b irector, page 2 s	mpl	Coronary Artery	diseas	e		24a. Was a autops perfori	sy prior t	autopsy findings available o completion of cause of ?
<u></u>	n: Tr ficate or, pag		25. Was case referred to medical			00 Pi(P	1□ Yes	2 ⊠ No 1 □ Yo	es 2🗷 No
	/sicla s certi	o Be	examiner? 1 Yes 2 No Hospital: 1 Inpati	ient 2 ☐ ER/Outpati	ient 3 DOA Oth	ier.	th (Check only on	ence 6 ⊡Other (Si	necify)
0	g Phy er thi	n: To	27. Manner of Death 28a. Date of Inj	ury 28b. Time	of 28c. Inju		· · · · · · · · · · · · · · · · · · ·	ow injury occurred	occuy)
0	ath. or: Aft	atio	2 Accident investigation	iy rear)		Yes 2 □ No			
Division or	or Atter fter de Directe in by ti	Certification:	3 Suicide 6 Could not be 4 Homicide determined 28e. Place of in building, e	jury - At home, farm, tc. (Specify)	street, factory, office		28f. Location (Si City or Town	treet and Number or n, State)	Rural Route Number,
	pital o		29a. Certifier 1 ☐ Certifying Physician: To the best	t of my knowledge, de	eath occurred at the 4	me date and place	and due to the o	ratico(c) and manner	as stated
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	edical	(Check only one) 2 Medical Examiner: On the basis one) 2 Medical Examiner: On the basis one)	of examination and/or					
	To the within To the complex c	Me	29b. Signature and title of certifier	1.1	29c. Licens	se number		29d. Date signed (Mo	
	111		Lavanye Yarlagac	xole Mi	D5	9027	-	08-13-	2008
,	6+11A		30. Name and address of person who completed cause of Lavanya Yarlagadda MD,	death (item 23a) (Typ	pe, Print)	uik 204 h			
		to-	31 Date filed (Month, Day, Year) 32. Regist	trar's Signature		,,		,	
	Sta Registi		AUG 1 4 2008	en &	Sparte				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 2008 1 - For State Registrar 27764 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death August 11,2008 Year Priscilla Chen 6:19pm M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb 177, 1911 9. Birthplace (State or Foreign Country)
China Social Security Number 7. Age (In yrs. last birthday) 1 ☐ M 2 💢 F 550-72-5000 97 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits tyEYes 2 □ No MD Montgomery Chevy Chase 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4450 S. Park Ave 20815 United States 12. Was Decedent Ever in U.S. Armed Force ? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Chinese 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) T.Y. Chang M. Tsai 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hong M. Chen / Husband 4450 S. Park Ave, #907, Chevy Chase, MD 20815 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Termation 3 ☐ Removal from State Metropolitan Crematory 8-12-08 Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's sons, INC 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Pneumonia

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show

ral", or items 23a or 28a-f shov Examirer mast be notified at

Director

Funeral

Completed by

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with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 239 any Injury or other traumatic event, the Medical

Be Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral inverted injector, page 2 should be detached for use as the burnal-transit Medical Certification: To

Division of Vital Records, P.O. Box 68760,

	Due to (or as a consequence of):		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consequence of):		
Cause (Clasade or injury that initiated events resulting in death) Last	Due to (or as a consequence of):		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ∐Yes 21 No 9 ∐Unknown	3c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 3 □ Ectopic pregnancy 4 □ Pregnant at time of death 5 □ Other (specify)	23d. Date of Month	delivery Day Year
Part II. Other significant conditions con Sepsis	ntributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute 1 ☐ Yes 2 H No 3 ☐	
		performed? death	e autopsy findings available to completion of cause of 1? Yes 2 □ No
25. Was case referred to medical examiner?	26. Place of Dea	ath (Check only one)	
1 Yes 2 MNo	ospital: 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Other: 4 🗆 Nursing F	forme 5 Residence 6 Other (S	Specify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Solution of S	28d. Describe how injury occurred	
3 ☐ Suicide 6 ☐ Could not be	28e. Place of Injury - At home, farm, street, factory, office	28f. Location (Street and Number or	

29d. Date signed (Month, Day, Year)

2008

Registrar

State

To the ...

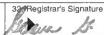
within 24 hours.

To the Funeral D'

31. Date filed (Month, Day, Year) AUG 13 2008

and title of certifier

29b. Signature



and manner stated

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



Brian Carpenter, M.D. 9901 Medical Center Drive, Rockville, MD 20850

2640

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** August 12, 2008 11:10 p Jane Enis Dipangrazio /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Carroll Sykesville Copper Ridge 8. Date of Birth (Month, Day, Year) July 11,1928 If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Maryland **Funeral** Months Days 1 ☐ M 2 🛣 F 80 212-26-0712 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location 10a. State 10b. County "natural", or items 23a or 28a-f show adical Examiner must be notified at 1 ☐ Yes 2 No Mt. Airy Director Carroll Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21771 USA 2911 Timber Ridge Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: white 3altimore, Maryland 21215-0036 Completed by 3 Widowed 4 □ Divorced Year or Dates: 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natur any injury or other traumattc event, the Madical E 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Anna Marie Ennis Raymond Parks 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 125 Stoner Avenue, Westminster, MD 21157 Gail Jones, guardian 20b. Place of Disposition (Name of Scientify, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Winfield, MD 8/15/2008 Carroll Crematory 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service License 91 Willis Street, Westminster, MD 21157 R Approximate Interval Between Onset and Death 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, strock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) fundation **Physician** Pass /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transil Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 ☐ Ectopic pregnancy Month Day 5 Other (specify) 1 ☐ Yes 2 No ed by the a 9 ☐ Unknowr cate has been signed by page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy certificate has performed 2 🗖 1∏ Yes Hospital or Attending Physician: funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 2[7] No 3□ DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 🔲 Inpatient 2 ER/Outpatient 1 🗌 Yes Certification: To After this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27. Manner of Death Injury 1 Natural 5 Pending investigation 24 hours after death.

The funeral Director: Af oletely filled in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 24 hor To the Fune the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier WIL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13 Willow 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 4 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Padmasudha Month **Physician** Doppalapudi 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner The Johns Hopkins Hospital **Baltimore City** | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Month Days | Hours | Min. | April 8 1971 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🔀 F 37 Yrs India 221-90-9819 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10a State 10b County 10c. City, Town or Location 1 ☐ Yes 2 No Funeral Director Delaware New Castle Newark 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 16 Thomas Lane North India 19711 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify: Asian Indian 1 ☐ Yes 2 ☐XNo Specify ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Computer programmer Computer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Rama Mohanrao Mandava Leela Kumari Tatineni ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Srinivasa R. Doppalapudi 16 Thomas Lane North Newark, DE 20a Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3X Removal from State Hockessin Crematory Aug 16 2008 Hockessin, Delaware 4 ☐ Donation 5 ☐ Other (Specify) Company 22. Name and Address of Facility 21. Signature of Funeral Service Lig Wilmington, DE 1 2506 Concord Pike Chandler Funeral Home 231. Part 1. Enter the disease, or complications that caused the deal shorts, or heart failure. List only one cause on each line. anot enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disseminater disease or condition resulting in death) /Medical Examiner aplastic anem Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physiclan/Medical IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 No Pregnant at time of death Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 ☐ Yes 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA မ 6 Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1X Natural 2 Accident 1 🗌 Yes 2 No eral Director: A 3 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide e Funeral I 1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basic of examination and/or impedication in the property of the pr 29a. Certifier (check only Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES-000 August 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 600 North Wolfe St, Baltimore, MD, 21287 trendonk an 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

the Hospital

DHMH 17 Rev 1/2001

Registrar

29b. Signature and title of certifier

2008

29d. Date signed (Month, Dav. Year)

and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

12,3008

August

Annabelle Darby

		- State Registrar			Cert	ificate of L	Death			Reg. No.	2008	27769
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		The Johns Hopkins 5. Social Security Number	· · · · · · · · · · · · · · · · · · ·			Baltimore		0411 1	- 5		1.55	
Funeral	ı		6. Sex 7. A	ge (In yrs. la 65	st birthday) Yrs.	Months Days	If Under Hours	Min.	8. Date of Bir (Month, Da	y, Year)	9. Birti	hplace (State or Foreign untry)District
Director	-	213-40-5785 Usual Residence of Decedent	Λ		113.				Dec. 2	8,194	2 of	Columbia
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ages nt of . If it		1 Burial 2 Tremation	3 Removal from State	Atí	metery, crem	catory or other place Cremator	ve)	Auguš	# 12,		,	, Maryland
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	ŀ	4 ☐ Donation 5 ☐ Other (S) 21. Signature of Funeral Service L			L	Name and Addre						
Depa Impo any I		Kn166	2.19	One	Ba	rranco &	Sons	y, P.	A. Seve	erna l	Park Fu	meral Home
	+	23a. Part 1. Enter the disease, of	complications that cause	d the death	49	5 GOV. R	1 Fch1	P HW	V. Seve	erna I	Park, M	D 21146 Approximate
		hock, or leart failure. List of Immediate Cause (Final	only one cause on each I	ine.		-,	3		, , , , ,			Interval Between
Physician // / / / / / / / / / / / / / / / / /		disease or condition resulting in death)	a. SEPS									Onset and Death
Examiner						JOLANI	c , ,	/				3 M DAITHE
	ĕ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. ASCEN	s a consequ	ence of):	HULAN	0111.	2			-	3 MONTHS
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or Att	Certification:	4 Homicide determ	inod 200. Flace of II	ijury - At nor etc. <i>(Specify)</i>	ne, tarm, stre	et, factory, office		2	8f. Location (City or Tov		Number or Ru	ıral Route Number,
5 J C =	ပ္	29a. Certifier 1X Certifyin	ng Physician: To the best	of my know	ledge death	occurred at the tir	no date ar	nd place s	and due to the	cource(c) a	and manner as	stated
To the Hospital or Attend within 24 hours after death To the Funeral Director: A completely filled in by the	edical	(check only 2 Medical one)	Examiner: On the basis and manners	of examinati	on and/or inv	estigation, in my o	pinion, de	ath occurr	ed at the time	, date and	place, and due	e to the cause(s)
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. 10	}	30. Name and address of person	011		23a) (Tune 1					1000	- '10	1,2003
20			CARWAL			iiii)		600 N	lorth Wo	olfe St.	Baltimo	re, MD, 21287
Stat	е	31. Date filed (Month, Day, Year)	32 Regist	rar's Signatu	ire							,,
Registra	ır	AUG 1 3	2008	u B	April	We .						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

4		_ For		State	of Maryla	and / Dep	artment of H	lealth and I	Mental	Hygiei	ne		
		State Registrar AD	nended#	23a perM	D, FCHD,	KS Ce	ertificate of	Death 8/1	L3/08	Reg.	No:2	8	27770
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/Medic Examin		4a. Facility Name (//	f not institution	n, give street and n	iumber)			r Location of Death			4c. County of		
		Citizens	Care	& Rehabil	litatio	n Ctr.	Frederi	ck			Frede	ric	k
Funeral Director		5. Social Security N 220-10-5		6. Sex 1 ☐ M 2 🂢 F	7. Age (In yi	rs. last birthday Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of (Mont) FEB.	of Birth th, Day, Ye	ari I	Count	ace (State or Foreign try) Land
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The law requires that the death certificate has been signed by the attending lage 2 should be detached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent	t pregnant	23c. If yes, c	outcome pf preg	gnancy	□Ectopic pregnance				23d. Date o	f deliver	ry
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3	-	30. Name and addr	ess Pperson	who completed ca	use of death (It	tem 23a) (Type	Print)	A	,		08-11- den	1	
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State of Maryland / Department of Health and Mental Hygien [] [] | | 1 - State Ragistrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Shirley GOLDMAN August 9 2008 8:00 P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3330 N. Leisure World Blvd., #907 Silver Spring Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) June 14, 1 Birthplace (State or Foreign Country)
 New York 5. Social Security Number If Under 1 Year | If Under 24 Hrs. **Funeral** 1□M 2XF Days Hours Director 1920 121-07-6439 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Menial Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Marvland Montgomery Silver Spring 10e, Street and Number 10g. Citizen of What Country? 3330 N. Leisure World Blvd., #907 20906 United States Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Tes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: white þ Specify: 3 V Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Dry Cleaning Business 0wner 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Jake Rosenstein Rebecca (unknown) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen Levine, Daughter 1516 Billman Lane, Silver Spring, MD 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) King David Memorial Garden 08/12/08 Falls Church, VA 21. Signature of Funeral Service License Torchinsky Hebrew Funeral Home Part1. Entit the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, which Constitute Constitutions are such as cardiac or respiratory arrest, which Constitutions are such as cardiac or respiratory arrest, which Constitutions are such as cardiac or respiratory arrest, which Constitutions are such as cardiac or respiratory arrest, and the constitution of th 20012 23a. Part1. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Atherosclerotic Cardiovascular Disease Physician 10 Years /Medical Due to (or as a consequence of): Examiner 30 Years Hypertension Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Physician/Medical attending pr IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4 Pregnant at time of death 5 Other (specify) ed by the a signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Y Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Yes 2. No 2 No 1□ Yes 1 Yes To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: ၉ Other: 4 🗆 Nursing Home 🖈 Residence 6 🗆 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After thi 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury at Work? 1 Natural 5 Pending 24 hours after death. e Funeral Director: A investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of molling D 0050612 August 11, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Samuel G. Maller, M.D., 3305 N. Leisure World Blvd., Silver Spring, MD

Registrar

State

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year) AUG 13 2008



State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 12, Maureen P. GOLDSMITH 2008 6:55 P M August /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Hospice Casey House Rockville Montgomery 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🗓 F Months Days Hours Min. Director 579-36-4582 28, 1931 Feb. Washington, Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d, Inside City Limits r than "natural", or items 23a or 28a-f show Directo 1 ☐ Yes 2X No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 226 Thistle Drive 20901 Funeral United States 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces?
1 ☐ Yes 2 ☐ Xio 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo <u>\$</u> Specify Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 72 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 should be filed w h and Mental Hygie 7 is marked other ti <u>Teacher</u> Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev ဂ္ William Pomerantz Sarah Malnick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Fural Foute Number, City or Town, State, Zip Code) Andy Goldsmith, Son 3121 Bunker Drive, Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)
21. Signature Fundal Service Licent Mt. Lebanon Cemetery 08/14/08 Adelphi, MD Torchinsky Hebrew Funeral Home 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) Ovarian Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Physician/Medical Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): the attending pt for use as the . nse IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day 1∐Yes 2 □No 5 ☐ Other (specify) P.O. 9 Unknown 9 Unknown s been signed be should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has page 2 autopsy performe 1 ☐ Yes 2 XNo 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: ${}_{4}\square$ Nursing Home ${}_{5}\square$ Residence ${}_{6}$ X Other (Specify) Hospice 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation s after death.

I Director: Af in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and man erstated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 0064615 August 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Génevieve Wrobelewski, M.D., 6001 Muncaster Mill Road, Rockville, MD 32. Registrar's Signature 31. Date filed (Month, Day, State 14 AUG Registrar

State of Maryland / Department of Health and Mental Hygieney Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** August 11 AM 2008 Robert Gross /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Doctor's Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 0 3 / 1 7 / 9. Birthplace (State or Foreign Country)
Washington DC 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1X M 2□ F Yrs. 65 217-44-3378 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Exa air er must be notified at 1 Yes 2 □ No Director MarylandPrince Georges Capital Heights filed within 72 hours after death with the 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 6801 Greig Street Apt. 102 20743 Completed by Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 K No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ould be filed withir Mental Hygiene. Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Truck Driver Moving Company ulth and Mental Hygie 27 is marked other I rtraumatic event, II 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be . Pages 1 and 2 should be timent of Health and Ments tant: If item 27 is marked 2 Unknown Graham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joel Gross/ Son 5803 Robin Lane Suitland, Maryland 20746 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/14/08 Clinton, Maryland Resurrection 21. Signature of Foreral Service Licensee 22. Name and Address of Facility Adams Funeral Home PA 191 20605 Aguasco Rd. Aguasco, Maryland20608 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** ASPIRATION PNEUMONITIS CAUSING /Medical RESPIRATORY Due to (or as a consequence of): Examiner FAICURE Section fally list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner law requires that the death certificate be executed FSOFHAGERAL TERMINAL Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ₫ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Winknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Hospital or Attending Physician: The performe 1 □ Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 ₩No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural ours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) august 8, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Shobhit Arora SIN Good Lick Road Lanham, Md 20706 31. Date filed (Month, Day, Year) AUG 1 4 32. gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month 1717 hrs August 20, 2008 **Medical Examiner** Melanie L. Gray 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Prince George's Cheverly Prince George's Hospital Center 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year | If Under 24Hrs. 5. Social Security Number Age (In yrs. last birthday) **Funeral** Foreign Wash., Months Days Hours Country) Director 03-03-1979 29 DC Yrs 579-98-4214 1 M 2 XF Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 X Yes 2 No DC Washington, D.C. Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe or items 23a or 28a-must be notified at 20019 USA 2701 Minnesota Ave., S.E. permit. Pages I and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a injury or other traumatic event, the Medical Examiner must be notified. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S White, etc. Armed Forces? 1 X Never Married 2 Married 2 X No Yes **Black** Specify Yes 2 X No specify: Divorced If Yes, Give Year 3 Widowed à 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Nursing Home Cert. Nursing Asst. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Robin Gray Be Bennie Rogers 196 Mailing Address (Street and Number of Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Robin Gray (Mother) Hyattsville, Maryland 20785 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 08-30-2008 Clinton, MD Resurrection Cem. Donation 5 Other Specify: on Williams Funeral Service 3 Potomac Ave.,SE; Wash., DC anature of Funeral Service Licenses 20003 23al Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death . Probable congestive heart failure associated with Due to (or as a consequence of): the postpartum period Immediate Cause (Final disease xaminer or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and transit Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. 23a,27,perME, g884 10/30/08 TT Physician/Medical XUNPENDED AMENDED physician a Box 68760. 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Year Month Day 1 V Live birth Fetal death 3 Ectopic pregnancy led by the attending detached for use as t past 12 months? Pregnant at time of death Aug 6, 2008 Other (Specify) 5 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 1 Yes 2 No 3 Probably 4 🗸 Unknown 2 Completed 24a. Was an 24b. Were autopsy findings available peen : autopsy prior to completion of cause of certificate has death? performed' ✔ Yes 2 1 🗸 Yes No 26.Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Other₄ Nursing Home 5 Residence 6 DOA Inpatient 2 V ER/Outpatient 3 this 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Director: Pending the 2 Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be Suicide or Town, State) 24 hours a (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie August 21, 2008 O.C.M.E.

(i)

31. Date filed (Month, Day, Year) State

Patricia Aronica-Pollak MD

AUG 2 5 2008

32. Registrar's Signatur ORIGINAL

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

OCME

Registrar

		1 - For State Registrar 1. Decedent's Name (First, Middle, Last)	State of Marylar	nd / Dep	artme <i>rtifica</i>	nt of H te of L	ealth ai Death			Reg. No.	2008		27775
Physicia /Medic Examine	al .	Vivian Holland 4a. Facility Name (If not institution, give st	treet and number)		1		Location of	Death	Month 129 Mg	7 Pay 4c.	- 200 County of De	8 1 eath	:06 P.M
Funeral Director		210-24-0403	7. Age (In yrs.	last birthday) 78 Yrs.	If Und	en Brant Pear Days	urnie If Under 2 Hours	4 Hrs. 8. Min.	Date of Bir (Month, Da)ec 2	th		Guntry)	e (State or Foreign
e Maryland 8e-f show	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Anne Art		ty, Town or L Sentor	1								Inside City Limits 1 ☐ Yes 2 ☐ No
be filed within 72 hours after death with the Maryland tal Hygiene. d other than "natural", or flems 23a or 28a-f show event, the Medical Exeminar must be notified at	by Funeral Directo	10e. Street and Number 204 Winer Rd. 11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	2. Was Decedent Ever in U Armed Forces? 1 □ Yes 2 N No If Yes, Give Year or Dates:	J.S. 13.	Was Dec	ecify Cuba		in? (Specif Puerto Ric	fy Yes or No can, etc.)	J	zen of What JSA 14. Race - A Black, W Specify:	merican	Indian,
within 72 hour jene. iene. than *natural he Medical E.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	ation	(Give	kind of w DO NOT	ual Occupa ork done d use retired,	furing most ()	of working			nd of Busine	ss/indus	try
should be filed ind Mental Hygi marked other umatic event, I	To Be Co	17. Father's Name (First, Middle, Last) Thomas Blake 19a. Informant's Name/Relationship (Typ)		10h Ma:8			18. Mother	a Da		, Maiden		e. Zin Co	de)
1 and 2 s Health ar tem 27 is other trau		Michael Holland 20a. Method of Disposition 1 X Burial 2 Cremation 3 Re	(Son)		Hil.	ltop ame of other place	Lane		t N	Anna 20c. Lo	cation - City	or Town	48.2140
permit. Pages Department of Important: If it any injury or o		21. Signature of Funeral Service Licenses **Aurus H. Bees		1	Mame	P CARGOS	of Cility	ons	Mort	uary	7, P.	A	
Physician /Medical Examiner		23a. Part1. Enter the disease, of complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	e cause on each line.	quence (1):	in the mo	avat	g, such as c	cardiac or r	espiratory a	rrest,		In	oproximate terval Between nset and Death
te be ysicia se bur	lical Examiner	Sequentially list conditions, if any, leading to immediate cause. Erner University Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consec										
he death certifical the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 pronths? 1 □ Yes 2 No 9 □ Unknowh	ac. If yes, outcome of pregn 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of 6	el death 3	⊒Ectopic ⊒ Other (pregnancy specify)					23d. Date of Month	delivery Da	ıy Year
The law requires that the de ate has been signed by the a bage 2 should be detached !	ρ	Part II. Dther significant conditions cont	tributing to death but not re	sulting in the u	ınderlying	cause give	en in Part I.			tobacco u Yes 2		e to the o	cause of death? ly 4 DUnknown
	Completed	Of Was save referred to modified					00 81	-1 Davib (1□ Yes	psy ormed? 200 No	24b. Were prior death	to comp	findings available letion of cause of
ding Phy h. After this funeral d	tion: To Be	27. Manner of Death 1 Natural 5 Pending	ospital: 1 Inpatient 2 C 28a. D te of Injury (Month, Day Year)	ER/Outpatie 28b. Time o Injury		28c. Injury Work	er: 4 □ Nur	sing Home	Check only 5 ☐ Resid. Describe	idence	6 □Other (5	Specify)	
or Atten after deat Director.	Il Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special dician: To the best of my kn	ify)	reet, facto	ery, office		28	City or To	wn, State	·) 		loute Number,
To the Hospital within 24 hours To the Funeral completely filled	Medical	(Check only one) 29b. Signature and title of certifier	er: On the basis of examin and manner stated.	ation and/or in	rvestigatio	9c. License	oinion, death	h occurred	at the time	, date and	d place, and te signed (M	due to th	e cause(s)
40m		apri openio. 31	mpleted cause of death (Ite	m 23a) (Type	Print)	in B	WHE	. 1	mb.	210	b/.	r 2	V &
Sta Registra		31 Date tiled (Month, Day, Year) AUG 1 3 20	32. A gistrar's Sign	ature	Some	12							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 20 Gertrude I. Hawkins 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 9. Birthplace (State or Foreign Country) Maryland If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Oct 16 19 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 □ M 2√2 F 79 Yrs. 1928 220-30-3776 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Anne Arundel West River 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5152 Cedarlea Dr. 20778 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐Yes 2√☐No Black Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Domestic Private Family 12th 0 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John H. McGowan Blanche A. Riddick 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Smith(Daughter) 5152 Cedarlea Dr. West River, Md. 20778 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 MBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Veteran 8-14-08 Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Williame Reactes of Collisions Mortuary, P.A. 21. Signature of Funeral Service Licenses 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, I'm Medical Evaminar must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Director

Funeral

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Completed

Be

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29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 1 3 2008

30. Name and address

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely lifled in by the funeral director, page 2 should be detached for use as the burlar-transit

Division of Vital Records, P.O. Box 68760,

	resulting in death)	Due to (or as a consequence of):	enal dise	n 17	
Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of)	enou cise	asc	
dical Exa	resulting in death) Last	Due to (or as a consequence of):			
Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown		oic pregnancy (specify)		23d. Date of delivery Month Day Year
ted by Pl	Part II. Other significant conditions co	ontributing to death but not resulting in the underlying in the un	ng cause given in Part I.		use contribute to the cause of death?
Comple				24a. Was an autopsy performed2 1 □ Yes 2 □ No	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No
Be	25. Was case referred to medical examiner?		26. Place of Dea	th (Check only one)	
	1 Yes 2 No	Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐	DOA Other: 4 Nursing H	ome 5 🗆 Residence	6 ☐ Other (Specify)
ation:	27. Manner of Death Natural 5 Pending Accident investigation		28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how inju	ry occurred
Certific	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, fac building, etc. (Specify)	ctory, office	28f. Location (Street at City or Town, State	nd Number or Rural Route Number, e)
Medical Certification: To	29a. Certifier (Check only one) Certifying Phy 2 Medical Exam	ysician: To the best of my knowledge, death occur iner: On the basis of examination and/or investiga and manner stated.	rred at the time, date and place tion, in my opinion, death occu	e, and due to the cause(s rred at the time, date an	s) and manner as stated. d place, and due to the cause(s)
Ĭ	29b. Signature and title of certifier		29c. License number	29d Da	ate signed (Month, Day, Year)

29c. License number

M0065117

29d. Date signed (Month, Day, Year)

Monica Sainz

Registrar

f death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** Robert Holbrook M. 2008 5 4:35p Aug. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4439 Dave Rill Road Hampstead Carroll If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 ★M 2 ☐ F 77 214-28-5862 Director 7/29/1931 MD Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hyglene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or items 23a or 28a-f show unty or other traumatic event, the Medical Examiner must be notitied at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Carroll Hampstead 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4439 Dave Rill Road 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 ☐ No 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc 1 Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2√2 No Specify: Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 building contractor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Marshall Holbrook Mary Greenwalt 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra Joan Holbrook, wife 4439 Dave Rill Rd., Hampstead, Md. 21074 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Carroll Cremation 8/11/2008 | Hampstead, Md. 5 Other (Specify) 4 □ Donation 22. Name and Address of Facility M00741 Eline Funeral Home Slow 934 S. Md. 21074 Main Street, Hampstead, Semme Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. WMA Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Exami the burial-tran Due to (or as a consequence of) Box 68760 attending physician Physician/Medical as IF FEMALE use 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) Division or Vital Records, P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use Intribute to the cause of death? Medical Certification: To Be Completed by No 1 TYes 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has I page 2 autopsy performe 1 ☐ Yes 2 ☐ No 1∐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only the) Other: 4 Nursing Home 1 ☐ Yes 1 | Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) After this 28a. Date of Injury (Month, Day Year) 27. Manne of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No r death. investigation 24 hours after death Pruneral Director: 6 ☐ Could not be determined 3 ☐ Suicide 28e. Place of injury. At home, farm, street, factory, office building, et. (Specify) filled in by Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only within 24 the 0 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar
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ompleted cause of death (Item 23a) (Type, Print)

	1 State of	Print in Black Indelible Maryland / Department of Certificate of	of Health and Mental Hy	giene	2008 277
	Registrar 1. Decedent's Name (First, Middle,Last) Sandra Oliver Har	ich	6 3	Reg. No. 2. Date of Death Month Day August 9, 2008	Year 3. Time of Death 1715 hrs
	4a. Facility Name (if not institution, give st	reet and number)	4b. City, Town, or Location of Death Silver Spring	Мо	ounty of Death ntgomery
Funeral Director		7. Age (In yrs. last birthday) 2 xF 45 Y	Months Days Hours Min.		0/YYYYY) 9. Birthplace (State or Forei Country) 1962 California
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	Usual Residence of Decedent	10c City, Town or Local		10g. Citize	10d. Inside City Limit 1 Yes 2 XN n of What Country?
r death with the Mortified or 23a or 2 or items 23a or 2 must be notified Funeral Dir	11813 Goodloe Roa 11. Marital Status 1	2. Was Decedent Ever in U.S. 13. W	20906 /as Decedent of Hispanic Origin? (Spr Yes, specify Cuban, Mexican, Puerto I		Race - American Indian, Black, White, etc.
wrs after dea ntural", or it aminer mus d by Fur	3 Widowed 4 X Divorced If	Yes 2x No Yes, Give Year Dates: highest grade completed) 16a. Decede	Yes 2 X No specify: ent's Usual Occupation (Give kind of w	Sylvork done 16b. Kin	pecify: White d of Business/Industry
5-0036 ed within 72 hour tygiene. other than "natu	Elementary/Secondary (0-12) 12 17. Father's Name (First, Middle, Last)	College (1-4 or 5+)	most of working life. DO NOT use reting	ed) (First, Middle, Maiden St	Grocery Store
21215-0036 oold be filed within 7 d Mental Hygiene, s marked other than lie event, the Medica	Gene Alan Oliver 19a. Informant's Name/Relationship (Type	e, Print) 19b. Maili		naron Shipp	
re, MD s 1 and 2 sho f Health and If item 27 is or traumati	Jaclyn Settersten, 20a. Method of Disposition 1 Burial 2 Cremation 3	20b. Place of Dispo	Clark Road, Lot Consistion (Name of cemetery, other place)	Date 20c. Lo	MD 20794 cation - City or Town, State
Baltimore, bermit. Pages I an Department of Hee Important: If ite	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	Metropol 22.	itan Crematory Name and Address of Facility Crancis J. Collins	Funeral Ho	exandria, Virgin
Physician /Medical .xaminer	23a. Part I. Enter the disease, or complica failure. List only one cause on each	itions that caused the death. Do not enter	00 University Blu	<i>r</i> d, W., Silt	ver Spring, MD 2
rsit Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Decease of kilgry that initiated	e to (or as a consequence of):			
e executed rian and rial - transit	d.	e to (or as a consequence of): WENDED INF, 8-25-08, E	Mili Maca	_	
b. Box 68760, the death certificate be only the attending physicis ched for use as the burier Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnancy 1 Live birth 2 Frequent at time of death	Tetal death 3 Ectopic pregnal		Date of delivery Ionth Day Year
ires that the d signed by the be detached d by Phy	Part II. Other significant conditions co		underlying cause given in Part I.		e contribute to the cause of death? No 3 Probably 4 Unknow
Records, P.O. Box The law requires that the death ficate has been signed by the atte page 2 should be detached for a Completed by Physi				24a. Was an autopsy performed? 1 ✓ Yes 2 No	24b. Were autopsy findings availar prior to completion of cause of death? 1 ✓ Yes 2 No
Vital Pysician: his certifi director, o Be C	25. Was case referred to medical examiner? 1 Yes 2 No	pital: 1 Inpatient 2 ER/Outpatie	26.Place of Death (Check on 3 DOA Other University		ce 6 ✓ Other: Scene
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitedical Certification: To Be Completed by Physician/Medical Ex	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be	28a. Date of Injury FOUND: FOUND: Aug 9, 2008 28b. Time of FOUND: 1710 hrs 28e. Place of Injury - At home, farm, str	1 Yes 2 ✓ No eet, factory, office building, etc.		If Number or Rural Route Number, C
Di To the Hospital Within 24 hours a To the Funeral I completely filled edical Cert	4 Homicide determined 29a. Certifier 1 Certifying Physician (Check only one) 2 Medical Examiner: Or	(Specify) Single Family To the best of my knowledge, death occurrence to basis of examination and/or investig	urred at the time, date and place, and		manner as stated.
Ne Ten Park	29b. Signature and title of certifier	id manner stated.	29c. License number O.C.M.E.		ate signed (Month, Day, Year) st 10, 2008
State	Name and address of person who con Donna M. Vincenti, MD As Date filed (Month Pay, Year)		1 Penn Street, Baltimore, Mi	D 21201	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State AMEND#5.perfam.pgc8-21-08bj Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day **Physician** 8:59pm M James Edward Harris August 12 2008 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Fort Washington Fort Washington Medical Center Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 455-72-9269 **Funeral** Hours Months Days 10K M 2 □ F 65 1/29/1943 Fulbright, TX Director 578-46-3784 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show "natural", or items 23a or 28a-f shov edical Examiner must be notifled at 1 Yes 2 □ No Director Fort Washington Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20744 United States 7512 Blanford Drive Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 72 hours after 1X Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black à 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) is marked other than filed within Hygiene. D.C. Police Officer 12 D.C. Government other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 should be finance and Mental F Be Tisha Harris 2 Tommy Duncan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) ,1 and 2 st ,f Health ar Hem 27 is 7512 Blanford Drive Fort Washington, Maryland 20744 Yvonne D. Harris / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition permit. Pages 1 Department of H Important: If iter any Injury or oth 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 8/22/2008 | Triangle, VA Quantico National 22. Name and Address of Facility Pope Funeral Homes, P.A. 21. Signature / Funeral Service Licen 5538 Marlboro Pike Forestville, Maryland 20747 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Vertucular disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attending Physician: The law requires that the death certificate be executed burial-trai Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year for Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) signed by the a 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 100 3 ☐ Probably 4 ☐ Unknown 1 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform Wolesterol 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2⊠ No 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death.

I Director: A
d in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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31. Date filed (Month, Day, Year)

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			DONA LESKUSKI 31. Date filed (Month, Day, Year) LAR	GO, MAR	YLAND 20	774					
	Sta Registr	-	AUG 1 5 2008	Ken	JZ. Reyk	k	gnature	•									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Aubrey Harding Herndon, Sr. 3:05 A^M Aug 11 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Brooke Grove Nursing HOme Silver Spring If Under 1 Year Fif Under 24 Hrs. Montgomery Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) XXM 2□ F Months Days Hours Min 227 12 1698 86 Oct 21. 1921 Virginia Usual Residence of Decedent 10d. Inside City Limits 10a, State 10b. County 10c. City. Town or Location Maryland Montgomery 1 ☐ Yes 2 X No Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3296 Gleneagles Drive 20906 United States 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Deceden Ever III Armed Forces? 1▲□Xes 2□No WWII 1 Never Married 2 Married If Yes, Give Year or Dates 1 ☐ Yes 2√√No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) General Contractor Home Improvement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James Herndon Agatha Elizabeth Dobyns 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aburey Herndon, Jr. (Son) 38_Maryland Ave #531, Rockville, MD 20850 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State XXBurial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 3 □ Other (Specify) Resurrection Cemetery Aug 18,2008 Clinton, Maryland 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Alexandria Ferry Road, Clinton, MD Approximate Interval Between Onset and Death 23a. Part f. Ente cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or l art faile one cause on each lin Immediate C rise (Final disease or indition resulting in eath) DHY. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): resulting in death) Last Due to (or as a consequence of): IF FEMALE: yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month 5 Other (specify) 1 □Yes 2 □No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? autopsy performed 2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 The ursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1€ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident

Physician /Medical Examiner requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

Be

2

7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Modien Evanine must be notified

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, If a Ma

72 hours after

Baltimore, Maryland 21215-0036

Box 68760.

P.0.

Division of Vital Records,

To the Hospital or Attending Physician:

and burial-1 physician the use as attending p s been signed by the should be detached has le 2 s page certificate l

Examiner Physician/Medical

After this certification, I thin 24 hours are:

2 Completed Be Certification: To

Medical

State Registrar

27. Manner of Death

29b. Signature and title of certifier

29a. Certifier

(Check only one)

.6 ☐ Could not be 3 Suicide 4 Homicide

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 10301 Georgia Ave, Anuradha Arun, Silver Spring, MD 20902 31. Date filed (Month, Day, Year)

AUG 1 4

32. Registrar's Signature

08 Month

3. Time of Death

8:45 P M

 $\mathbf{2008}^{\text{Year}}$

4c. County of Death

12 Day

/land 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show an important: If item 27 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "Y any Injury or other traumatic event, the Med any Injury or other traumatic event, the Med Dice.

Physician

/Medical

DOROTHY

REBECCA

PILLOW HAYCRAFT

Physician /Medical

Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division or Vital Records, P.O. Box 68760

	4a. Facility Name (/	f not institution,	give stre	et and numbe	er)		4b. City, Town,	or Location of D	eath		y of Death	_	
	2702 SH 5. Social Security N	ERMAN D	RIVE 3. Sex	-1-		to a finish atomi	CHESTI If Under 1 Year		Hrs 8. Date of B		EN ANNE	(State or Foreign	
	579–14–8 Usual Residence of	992		2 X F	Age (In yrs. I	Yrs.	Months Days		lin. (Month, D	R 30, 1913	Country)	INIA	
	10a. State	10b. County			10c. City	, Town or Lo	cation				10d.	nside City Limi	
ţċ	MARYLAND	QU	EEN	ANNE'S			CHESTE	R				1 □ Yes 2 📉	
Director	10e. Street and Number				10f. Zip Code			10g. Citizen of What Country?					
							21619		UNITED STATES				
by Fur	11. Marital Status 1 ☐ Never Marr 3 ▼Widowed		d	Was Decedel Armed Force: 1 ☐ Yes 2 If If Yes, Give Year or Dates	s? X No	1	Was Decedent of f Yes, specify Cu I □ Yes 2 🛣 No		? (Specify Yes or N uerto Rican, etc.)	Bla	ice - American I ack, White, etc.		
etec	(Spec	15. Decedent's cify only highest	Education grade co	on <i>mpleted)</i>		16a. Deced (Give	lent's Usual Occu kind of work done DO NOT use retire	ipation e during most of	working	16b. Kind of E	Business/Indust	ry	
Completed	Elementary/Seco	endary (0-12)		College (1-4o	or 5+))MEMAKER	ea)		OUN	HOME		
ပ္ခ	17. Father's Name	(First, Middle, L	ast)			110	THINKLIN	18. Mother's	Name (First, Middl				
To Be	WILLIA	M THOMA	S PI	LLOW					MATTIE H	OLT			
	19a. Informant's N					19b. Mailir	g Address (Stree	t and Number o	r Rural Route Num	ber, City or Towr	n, State, Zip Co	de)	
	WILLIAM	HAYCRAF	T/SO	N		2702	SHERMAN	DRIVE,	CHESTER,	MARYLAN	ND 21619)	
	20a. Method of Disp			11 0:	20b. P	lace of Dispo	sition (Name of natory or other pl	ace) L	AUGUST 14	20c. Location	- City or Town,	State	
		Cremation 3 5 ☐ Other (Spe		oval from Sta	le		E CREMAT	, -	2008	STEVENS	SVILLE,	MARYLA	
	21. Signature of F	ineral Service Li	censee	-)	W27	F1	Name and Add	ess of Facility HELFENBI	EIN AND N	EWNAM FU	JNERAL I	OME, P	
	23a. Part1. Ente	he disa se, or c	omplicati	ns that caus	sed the death				diac or respiratory		Ap	proximate	
	Immediate Cause	Final	nly one o	te on		سيريد تيا	T CAN CER			Onse		erval Between set and Death	
	disease or condition resulting in death)	in .	_a	Due to (or a	as a consequ		Ch,	0 6614				UMO	
cal Examiner													
Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							ate of delivery Ionth Da	y Year				
-	Part II. Other signi	ficant condition	s contrib	uting to death	n but not resu	ulting in the u	nderlying cause g	iven in Part I.	23e. Did	tobacco use coi	ntribute to the c	e to the cause of death?	
ed by									_ 1□	Yes 2 No	3 Probabl	/ 4 □Unkno	
Completed									24a. Wa	s an 24b	. Were autopsy	findings availa	
Eo							per 1□ Yes	prior to completion of cause of death? 2 ☑ No 1 ☐ Yes 2 ☐ No					
Be C	25. Was case refer	red to medical						26. Place of	Death (Check only				
To E	examiner? 1 ☐ Yes 2 Z	No	Hosp	oital: 1 ☐ Inpa	patient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
Certification:	On Date of living 100 Pate of li									urred			
ertific	3 Suicide 4 Homicide 6 Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Factory, office building, etc. (Specify)									nber or Rural R	oute Number,		
O	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
edical	one)	0	11	and manner									
Medical C	29b. Signature and	title of certifie	11	and manner				ise number		29d. Date sign	ed (Month, Da)	r, Year)	
edical		the et ertifie	hu	and manner	~ .			37064		29d. Date sign	ed (Month, Da)	r, Year)	
edical		ress of person w	hu	ln		n 23a) (Type,	Print)	37064	Stevensv	29d. Date sign	- 1		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#24a, 29d, perPHYS., G882,8/28/08, WS

State of Maryland / Department of Health and Mental Hygiene 2 0 0 9 For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 1051 AM HYNES GLENNIS OPEL 08 06 2008 Eacility Name (If not institution, give street and number) 4c. County of Death eninsula Regional Medical Center 1) Come Birthplace (State or Foreign Country)
 MATNE If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) OCT. 22, 1929 6 Sex 1 ■ M 2 🕏 F 79 MAINE 041-32-0186 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits YXXYes 2 □ No ACCOMACK KELLER 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 23401 18142 1ST STREET Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ∐ Yes 2√X No If Yes, Give Year or Dates: 1 Never Married 2 Married WHITE 1 ☐ Yes 2XXNo Specify. 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DOMESTIC HOMEMAKER 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) EMMA JOHNSON (UNKNOWN FIRST) BELMAIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 31007 H. WEST AVE., KELLER, VA 23401 JOHN D. HYNES PO BOX 323. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XXCremation 3 ☐ Removal from State EXMORE, VA OCI CREMATORY 8/12/08 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility THORNTON FUNERAL HOME, INC. 24183 CHADBOURNE ST. - PARKSLEY, VA 23421 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1-2 MINTIES SYSIEN aron FILLURE a. MULTIPLE disease or condition resulting in death) Due to (or as a consequence of): COLOMPRY ARTERY 5 MINTS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy

1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably - FAILURE 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 2**X** No 1∐ Yes 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Injury 1 TYes 2 TNo investigation 6 Could not be determined

Examiner 68760 attending physician pe death certificate the Box the Ö signed by the ے or Vital Physician: funeral director, After this Hospital or Attending Division filled in by the Director: within 24 hours a

Examiner Physician/Medical þ Completed Be Certification: To Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

iral", or Items 23a or 28a-f shov Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after or Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Iten any Injury or other traumatic event, the Medical Examines once.

Physician

/Medical

Baltimore, Maryland 21215-0036

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Director

Funeral

Completed by

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death with the Maryland

VENTINGE DEPENDENC 25. Was case referred to medical examiner? 1 ☐ Yes 27. Mannes Death 1 Inatural 2 Accident 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29c. License number 29d. Date signed (Month Day Year) August 6, 2008 29b. Signature and title

Salisbury MD 2180,

State Registrar

10da 31. Date filed (Month, Day, Year) **AUG 28**

arroll 51

30. Name and addr s of person who completed cause of death (Item 23a) (Type, Print)

			For State Registrar	State of Maryland / Dep <i>Ce</i>	artment of He			giene 008	27784
	Diam'r.		1. Decedent's Name (First, Middle, I	.ast)			2. Date of Dea Month	ath Day Yea	3. Time of Death
	Physicia /Medic		Louise	Jones			- 5	903	1102 BM
i .	Examin	ęr	4a. Facility Name (If not institution, g	ive street and number)	4b. City, Town, or I	Location of Death	-	4c. County of De	
ı			wordski	Porce The Many tradition	If Under 1 Year	If Under 24 Hrs.	0 Date of Bird	my	
	. Funeral Director		5. Social Security Number 6. 577–48–8757	Sex 7. Age (In yrs. last birthday,	Months Days	Hours Min.	8. Date of Birth (Month, Day DEC 20	1934 WA	inhplace (State or Foreign SHINGTON, DC
Ш			Usual Residence of Decedent	X /3			DEC 20	1934 W21	DILINGTON, DO
	show ed all		10a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Limits
	Ma -1 s	ctor	MD PRINCE	GEORGE'S UPPER MAI	RLBORO				1√1 Yes 2 □ No
	ith th	Director	10e. Street and Number	_	10f. Zip Code			10g. Citizen of What	•
	ath w		1101 HOLCUM PL		20774			USA	
0000	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. It health and Mental Hygiene. Item 27 is marked other then "natural", or items 23a or 28e-f show other traumatic event, the Modical Examitient ratibe notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces?	Was Decedent of His If Yes, specify Cuban 1 ☐ Yes 2X No	spanic Origin? (Spe n, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ar Black, WI Specify:	nerican Indian, nite, etc. BLACK
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	I be fi	Be	17. Father's Name (First, Middle, La JOHN OLIPHANT	51)		SALLIE	DRUMM:	Maiden Sumame) TNC	
Š	should ind Men s marke umatic	ည	19a. Informant's Name/Relationship	(Type Print)	ing Address (Street a			or, City or Town, State	Zin Codo)
<u>0</u>	and 2 sho ealth and n 27 Is m		KAREN JONES/DAU					ORO MARYLA	
บั	thealth tem 27 other tr		20a. Method of Disposition	20b. Place of Disp	osition (Name of		Date	20c. Location - City	
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	그 된 원 글		21. Signature of Funeral Service the		2. Name and Address			ENKINS FUN	
ŏ	Depa Impo eny ir		1 Ki CI		7474 LAND	OVER ROAL	LANDO'	VER, MARYLA	ND 20785
P			23a. Part 1. Enter the disease, or co shock, or heart failure. List on	emplications that caused the death. Do not en	ter the mode of dying	, such as cardiac o	or respiratory ar	rest,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	m. L. 2. L.	- >	CA			Onset and Death
	/Medical		resulting in death)	a Due to (or as a consequence of):	2000				
	Examiner		Sequentially list conditions,	b. Breeze CA					
	ad sit	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence of):					
	and I-tran	Examine	that initiated events resulting in death) Last	c					
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O. DOX	The law requires that the death certificate be executed to has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)			23d. Date of o Month	delivery Day Year
ŗ	that i		Part II. Other significant conditions	s contributing to death but not resulting in the t	underlying cause give	n in Part I.	23e. Did to	obacco use contribute	to the cause of death?
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ב		Completed by					24a. Was autop	sy prior t rmed? death	autopsy findings available o completion of cause of ?
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	Jing After fune	Certification:	27. Manner of Death 1. ■ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work'	?	28d. Describe h	now injury occurred	
NISIOII NISIOII	Attendia death. ctor: A y the fu	icat	2 Accident investigat 3 Suicide 6 Could not	be 390 Place of laive. At home form of		es 2 No	28f Location /	Street and Number or	Rural Route Number
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	To the Hospitel or Attending within 24 hours after death. To the Funerel Director: After completely filled in by the fune.	edical C	29a. Certifier (Check only one) Certifying 2 Medical Ex	Physician: To the best of my knowledge, deal aminer: On the basis of examination and/or in and manner stated.	th occurred at the time	e, date and place, inion, death occurr	and due to the o	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
	withir To th comp	Me	29b. Signature and title of certifier		29c. License			29d. Date signed (Mo	nth, Day, Year)
)	Dille wo	Dua	57884		8/91	2009
1	(C)		30. Name and address of person	mpleted cause of death (Item 23a) (Type	Print) Dan	ien Dui	16	Ruce	an alle
_	•				1801	5 7059 5 7059	arsun	53	20823 20823
	Sta Registr	-	AUG 1 5 2008	32. Registrar's Signarie	· 				

			For State Registrar	State of M	laryland		artment rtificate			and M	-	giene Reg. No.	2008	27785
V ari	Physicia /Medic	al	1. Decedent's Name (First, Middle,	C. JONES	JR.		4b. City, 7	Four or I	ocation	of Death	2. Date of De Month AUGUS	ath Day	2008	3. Time of Death 1:00A M
i Serat	Examin Funeral Director		PRINCE GEORGE'	S HOSPITAL		a <i>st birthd</i> ay) Yrs.	CH]	EVERI		24 Hrs. 1	8. Date of Bir (Month, Da AUG 13	PF	RINCE GE	
21215-0036	flied within 72 hours after death with the Maryland illed within 72 hours after death with the Maryland it items 23a or 28a-f show the the Medical Evaniner must be notified at ent, the Medical Evaniner must be notified at	Completed by Funeral Director	Usual Residence of Decedent 10a. State 10b. County	12. Was Decedent Armed Forces' d 1	t Ever in U.S.	16a. Dece (Give life.	OL HE 10f. Zip 20	743 ent of His ify Cuban	panic Ori , Mexican <i>Specify:</i>	gin? (Spe	cify Yes or No Rican, etc.)	10g. Citiz U S	zen of What Cou SA 14. Race - Amer Black, White,	10d. Inside City Limits 1 ☐ Yes 2 ☐ No intry? ican Indian, etc. ACK
_	buid be Mental arked c	To Be C	17. Father's Name (First, Middle, Le EVERETT JONES	SR.					BEF	RNICE	P. HO	WELL		in Code)
ē,	permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is m any Injury or other traum once.		19a. Informant's Name/Relationship LYNNETT JONES/W 20a. Method of Disposition 1 [XBurial 2 □ Cremation 3 4 □ Donation 5 □ Other (Special Service Lieuward)	TIFE B□Removal from State		lace of Dispo emetery, crer VETER	LONG: esition (Nameratory or other) ANS C. 2. Name and	LEAF ne of ther place EMET	ROAI	3/20/ by J	TTOL H	20c. Lo CHEI	cation - City or T	LAND 20743
50,	ate be executed /Medical Examiner the burial-transit	ical Examiner	23a. Part 1. Enter the disease, or o shock, or heart failure. List of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. LUNG Due to (or a HYPER b. Due to (or a	CANCE IS a consequ TENSI IS a consequ TES M	K WITH uence of): ON uence of):	META			cardiac o	r respiratory a	arrest,		Approximate Interval Between Onset and Death
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ot Vital	iding Physician: The law th. After this certificate has b funeral director, page 2 sl	To Be	25. Was case referred to medical examiner? 1 ☐ Yes 2▼ No 27. Manner of Death	28a. Date of In	njury	ER/Outpatie		Othe	r: 4□ Nu	ursing Ho	(Check only	idence (6	2Ã No cify)
_	tal or Attending s after death. al Director: Afte ed in by the fune	Certification:	1 X Natural 5 Pending Investigation 2 Accident 3 Suicide 4 Homicide						d Number or Ru)	ral Route Number,				
	To the Hospital or Atten within 24 hours after deat To the Funeral Director: completely filled in by the	Medical (Physician: To the bes xaminer: On the basis and manner s	of examina		nvestigation		inion, dea			, date and		to the cause(s)
R	(8)		30. Name and address of person w	·			Print)	2967 AD C		RLY,	MARYLA			3, 2008
	Sta Registr		31. Date filed (Month, Day, Year) AUG 1 5 2008	32. Regis										

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Timothy	
08-06333	3

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State of Maryland / Department of Health and Mental Hygiene

Dia		Registrar Co. timodro C. Doda		Reg. N	· — — — —	V ter					
Physiciar Il Examin		1. Decedent's Name (First, Middle,Last) Timothy Jenkins		2. Date of Death Month Day August 19, 20	Year	3. Time of Death 0252 hrs					
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or PG Hospital Center Cheverly, N	Location of Death		4c. County of Death Prince George	's					
uneral	į	577-98-5026 1X M 2 F 37 Yrs. Months Day		8. Date of Birth (MI)	M/DD/YYYY) 9. Birtl 1971 Foreigi Cou	hplace (State or n DC untry)					
show any		Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 XYes 2 No					
sa or 28n-f	Dire	10e. Street and Number 10f. Zip Code 5307 Jay St NE 20019		10g. C	U.S.	Α.					
, or items 2.	Fune	11. Marital Status 1 X Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 1 Yes 2 X No 1 Yes 2 X No	n, Mexican, Puerto I		14. Race - Americ White, etc.						
h and Mental Hygines than "natural", or items 23a or 28a-f she card; marked other than "natural", or items 23a or 28a-f she imatic event, the Medical Examiner must be notified at once	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupa during most of working life	tion (Give kind of w	ed)	, Kind of Business/li						
I Hygiene. ed other than t, the Medical	e Comp	12th Laborer 17. Father's Name (First, Middle, Last) Charles Harris	18.Mother's Name Mary Je	(First, Middle, Maid	rivate en Surname)						
Health and Mental Hygi Hen 27 is marked other r traumatic event, the R	m l	19a. Informant's Name/Relationship (Type, Print) Timothy Demetri Dunn – Son 9526 Montr	et and Number or R	ural Route Number	City or Town, State Marlboro	, Zip Code) D Md 20772					
int: If item		20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of ce crematory or other place) Riverdale Park Riverdale Park	Aug 23,	ust 2008 R	c. Location - City or	e Md					
		June 1/ Min Inc, 2019	9 MLK Jr	Ave SE	Washing	Service gton DC 20 Approximate Interval					
sician edical miner	4	failure. List only one cause on each line.	failure. List only one cause on each line. Immediate Cause (Final disease a. Non-ischemic cardiomyopathy Between Onset and Death								
		Sequentially list conditions, b									
	iner	If any, leading to immediate cause. Enter Uncertainty Cause									
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Spiral of Artenning Physicians, The law requires that the death certuing the between the hours after death. Incral Director: After this certificate has been signed by the attending physician and y filled in by the funeral director, page 2 should be detached for use as the burial - tra	edical Certification: To Be Completed by Physician/Medical	If any, leading to immediate cause. Error Undrying Cause (Disease or injury that initiated events resulting in death) Last d. X UNPENDED AMENDED 23a,27,perME,g885 11/ IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	given in Part I. ce of Death (Check of Other Nursin ury at Work? Yes 2 No building, etc.	23e. Did tobact 1 Yes 2 24a. Was an autopsy performe 1 Yes 2 only one) 1 Bet 28d. Describe how 28f. Location (Streor Town, State) due to the cause(sat the time, date and	Month Co use contribute to No 3 Pro 24b. Were at prior to death? No 1 Y Sidence 6 Othe injury occurred et and Number or Re and manner as sta	Day Year In the cause of death? In the cause of deat					
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Susan Mason Kareiva 2008 11:20 August 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 28 Westmoreland Street Westminster Carroll If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Days Hours Min 1 ☐ M 2 🏋 F 62 **Director** July 18, 1946 214-46-4474 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location show 'natural", or Items 23a or 28a-f shov dical Examiner must be notified at 1 √Yes 2 No Westminster Directo Carroll MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 USA 28 Westmoreland Street and 2 should be filed within 72 hours after death veath and Mental Hygiene. m 27 is marked other than "natural", or Items 23s ner traumatic event, the Medical Examiner must Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 □ Never Married 2 □ Married 1 ☐ Yes 2X No Specify: Baltimore, Maryland 21215-0036 Specify: White þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp (Give kind of work done during most of working life. DO NOT use retired) grade completed) College (1-4or 5+) Elementary/Secondary (0-12) State of Maryland Unemployment Ins Specialist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Margaret Elliott Clarence Mason 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health a if item 27 is Owings Mills, MD 12 Woodhollow Ct. Stephen Kareiva/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Department of Important: If any Injury or once. 4 □ Donation 5 □ Other (Specify) Westminster Cemetery 08/09/2008 Westminster, MD 21. Signature of Funeral Service Licens Pritts Fine Fally Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pulmonan It. Due to (or as a consum nce of): pertension **Physician** disease or condition resulting in death) 1+-/Medical Examiner Obstructive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or se a consequence of) Examine The law requires that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical the 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Division or Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Diabetes 2 No 1 Tyes 3 Probably 4 Unknown Completed 24a. Was an

autopsy perforn 1∐ Yes

26. Place of Death (Check only one)

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death

5 ☐ Pending investigation

Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA 28a. Date of Injury (Month, Day Year) 6 □ Could not be

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

and manner stated. 29b. Signature and title of certifier may

29c. License number #53939 29d. Date signed (Month, Day, Year) 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD 218 Washington Heights Medical Ctr Westminster, MD 21157 Babak Imanoel,

State Registrar 31. Date filed (Month, Day, Year) AUG 0 8 2008



DHMH 17 Rev 1/2001

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To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, p.

Be

Certification: To

Medical

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Mary Ruth Lippy 2008 10:18 A M August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll County Carroll Hospice Dove House Westminster 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, **Funeral** Days Year Hours 1 □ M 2 X 1 F 218-32-8490 72 Director 12, 1936 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show or than "natural", or items 23a or 28a-f sho Maryland Carroll County Hampstead 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1210 Woodland Court 21074 United States Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Heatth and Mental Hygiene. nent of Heatth and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊡Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 Married altimore, Maryland 21215-0036 Specify: white 1 □Yes 2 X No Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Finance and Elementary/Secondary (0-12) College (1-4or 5+) Account Manager Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked any linjury or other traumatic evene. Treva A. Richarts Howard E. Carrett, Sr. ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1210 Woodland Court Hampstead, Maryland 21074 Richard D. Lippy - husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Aug. 13 2008 13, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Immanuel Lutheran Cem. Manchester, Maryland 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Filine Funeral Home 21. Signature of Funeral Service License 934 South Main Street Hampstead, Maryland 21074 M01072 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each limit. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine Due to (or as a consequence of): The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran Due to (or as a consequence of): P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 🗆 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an . Were autopsy findings available prior to completion of cause of autopsy performed 2ENo 1∐Yes 2∐ No 1 ☐ Yes e Hospital or Attending Physician: 24 hours after death, e Funeral Director: After this certifica letely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, Cify or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 ho To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatu and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) WIL

State Registrar

ALIC 1 9 2000

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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

555 S. CENTER

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 01:304 8977/2008 **Physician** Evelyn K. Leister /Medical 4b. City, Town, or Location of Death Frederick 4c. County of Death Frederick 4a. Facility Name (If not institution, give street and number)
Homewood at Crumland Farms Examiner 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign MDountry) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 0371841916 6. Sex Social Security Number 212-14-6350 **Funeral** Months Days Hours Min 1 M 2 XF Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at any Injury or other traumatic event, the Medical Examiner must be notified at angles. 1 X Yes 2 ☐ No Frederick Frederick Director MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21702 U.S.A. 7407 Willow Rd. by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Y Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Maryland 21215-0036 3 ₩ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Health Care Food Services 8 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jottie V. Houck Oliver M. Koontz 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 610 Harmony St.Apt 215 New Oxford PA 17550 Dixie L. Schaefer Dau. 20b. Place of Disposition (Name of cemetery, cramatory or other place)

Carroll Cremation Inc. Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead, MD 22. Name and Address of Facilit 6 / 8 / 0 8 Po Box 155 21. Signature of Funeral Service License italestown PA Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) un! **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Evelyn K. Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Be Completed by Physician/Medical attending p IF FEMALE: 23c. If yes, outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 □ Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Mnown tophysicians 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has the inector, page 2 s autopsy 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director. p ed to medical 26. Place of Death (Check only one) 25. Was case refer examiner? Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 1 Inpatient 2 ER/Outpatient 3□ DOA ဥ 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 27 Manner of Death Medical Certification: 5 Pending investigation **Iniury** Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier n who completed cause of death (Item 23a) (Type, Print) 30. Name and addr ss of per-9411 Frederick MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 1 2008

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Registrar

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State 31. Date filed (Month, Day, Year)

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32. Degistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death **Physician** August 2008 2245 Geraldine T. McKinney /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel 918 North Crain Highway Glen Burnie If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Dec 6 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2\□ F Maryland 78 218-32-8484 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No r 28a-f sh notifled Maryland Anne Arundel Glen Burnie Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ms 23a or 21061 USA 918 North Crain Highway Funeral ural", or items 2 14. Race - American Indian. 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. filed within 72 hours after 1 □ Yes 2 ▼ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 🎾 No Black Specify: Specify: þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Anne Arundel Co. Elementary/Secondary (0-12) College (1-4or 5+) than the permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygienn Important: If Item 27 Is marked other that any injury or other traumatic event, the one. Public Schools 12th 6yrs Educator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Myrtle M. Matthews Charles M. Thompson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crystal Doolittle(Daughter) 1606 Woodruff Ct. Severn, Md. 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □ Removal from State 8-13-08 Maryland Veteran Crownsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) Williame Reparts of Acidons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, physician a Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performe 1 Yes 2 No director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 2 this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 ☐ Could not be 3☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier an 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 Bestsate Rd Ste 300 Annapolis MD 21401 31. Date filed (Month, Day, Year) State AUG 1 3 2008 Registrar

			partment of Health and Nertificate of Death		jiene _{leg. No.} 2008	27792
Physic		1. Decedent's Name (First, Middle, Last) Nancy Carolyn McDowell		2. Date of Deat Month August	th Day 2 Year 14 2008	3. Time of Death 12:32 P M
/Med Exam		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Death	
A. A. C. C. C. C. C. C. C. C. C. C. C. C. C.		328 Smith Rd.	Rising Sun		Ceci1	
Funera Directo		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda 408-62-9175 6. Sex 6. Sex 6. Sex 7. Age (In yrs. last birthda 6. Sex 7. Age	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Feb. 22	(Year) Cou	place (State or Foreign intry)
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the N 28a-1	Director	10e. Street and Number	10f. Zip Code	1	0g. Citizen of What Cou	
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er dea	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Armed Forces?	B. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,	
Z1Z15-UU36 within 72 hours after death with the Maryland sjene. r than "natural" or items 23a or 28a-f show the Marian Evan increust be notified at	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Year or Dates:	1 ☐ Yes 2 X No Specify:			ite
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e, M 1 and 2 Health 9m 27 is		Harry Clay McDowell/Husband 328 20a. Method of Disposition 20b. Place of Disposition	Smith Rd., Rising			Chata
baltimore, pormit. Pages 1 and Department of Heal Important: If item 2 any injury or other ores.		Magadia 2 Li Crematori 3 Li Hemovarirom State	ematory`or other place)		20c. Location - City or T	
altimor			Cemetery 8-16- 22. Name and Address of Facility		Rising Sun,	Maryland
<u> </u>	ii)	Kichard L Cloodie	R.T. Foard Funera 111 S. Queen St.,	l Home,	P.A. Sup. MD 21	911
	ı	23a. Part 1. Enter the disease, or complical his that caused the death. Do not e shock, or heart failure. List only on course on each line.	nter the mode of dying, such as cardiac	or respiratory arr	est,	Approximate Interval Between
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		d				
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the Ho lin 24 l the Fu	edical	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, da	ate and place, and due t	to the cause(s)
Mith Con	Σ	29b. Signature and title of certifier	29c. License number	25	9d. Date signed (Month,	Day, Year)
10		30. Name arid address of person who completed cause of death (Item 23a) (Type	DC044373		8 14 20	08
10		Joseph K. Weidner, M.D., 101 Colonia	. ,	ising S	un. MD 219	11
	ate	31. Date filed (Month, Day, Year) AUG 1 5 2008	6)		-,	
Regist	rar	HUG I O COUD SHOW IN PA				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For Pegistrar Amended #28c perMD FCHD, KS Certificate of Death 8/13/08 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** August 9,2008 10:20PM L. Misner /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Golden Living of Frederick Frederick Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 □ M 2 🛛 F 215-34-2810 Yrs Director 87 Maryland Jan. 1, 1921 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r 28a-f show notifled at Maryland
10e. Street and N 10d. Inside City Limits Frederick Thurmont 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Pages 1 and 2 should be filed within 72 hours after death with ment of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or items 23a or any or other traumatic event, the Medical Examiner must be I 13320 Catoctin Furnace Road 21788 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify White Completed by 3X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Brice Minnie Belle Portner 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cindy Long/ Granddaughter 13320 Catoctin Furnace Road, Thurmont, MD 21788 Department of Heal Important: If Item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Blue Ridge Cemetery 4 Donation 5 Dother (Specify) 8/13/2008 Thurmont, MD 22. Name and Address of FacilityStauffer Funeral Home, PA 21. Sonature of Funeral Ser 104 E. Main Street, Thurmont, MD 21788 ard. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, buly one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician ATHENO Sclevosis DISEASE LORONARY disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner FIBRILLA TION ATRIAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examine The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) ned by the a 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Vonknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy performed death? 1 ☐ Yes 2 No 1 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only on Hospital: 1 ☐ Yes 2 No Other: Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural

Accident 5 Pending investigation Injury 1 Yes 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TREDERIUC

State Registrar

SIBTE A. KAZMIND

AUG 1

31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

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32. Registuer's Signature

1 - For State Registrar

		1. Decedent's Name (First, Middle	, Last)								2. Date of Dea				3. Time o	f Death
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/Medic		4a. Facility Name (If not institution			,		4h City	Town or	r Location o	of Death	0=-0	_	County of D			
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ms 3	Funeral	11. Marital Status	12. Was Dec		er in U.S.	13. V	Vas Deced	dent of H		igin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - A			
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Hygi Hygi Int, I		17. Father's Name (First, Middle,	l ast)		1 22	OIII 2.11 2.	berael				(First, Middle,	Maiden		Time		
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and salth		Leneta Hoover	- Daughter			709 V	enice	Drive	e, Silv	ver S	pring, Man	rylar	nd 20904	+		
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If the 72 is marked other than "natural" or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be nutified at once.		1 ☑ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State	Fort Li				~)	09/1/	+/2008	Ruan	twood	Ma	r1 and	
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be e lician buria			4	(0. 00 0	oonooquonoo	01).										
icate be executed	<u>i</u>		d											+		
eath certificate be executed attending physician and for use as the burial-transit	cian/Medical	IF FEMALE:														
ath c trend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, or	utcome of birth 2	f pregnancy ☐ Fetal deat	h 3	Ectopic p	reananc	v				23d. Date of		,	
. 0 00	Sici	1 ☐ Yes 2. ☑ No		gnant at t	ime of death	5 □	Other (sp	ecify) _					Month	1	Day	Year
The law requires that the date has been signed by the bage 2 should be detached	Physi	9 Unknown	3 LI UTIK	WINTER THE							T					
s this	by P	Part II. Other significant condition	ns contributing to	death but	not resulting	in the un	derlying c	ause giv	en in Part I		23e. Did to	bacco (use contribut	e to the	e cause of	death?
quires in sign	D E	Multiple.	ergan	+	ail	296	0				1 □ Y	es 2	No 3□] Proba	ably 4	Unknown
w requir	Completed	0	1							_	240 14/0-	nn.	24h W/5	01140	ov findin-	a available
ne lav has ge 2:	윤										24a. Was a autop: perfor	sy	prior death	to con	sy findings npletion of	cause of
icate	S											2.010			2□No	
Attending Physician: The kreath. setor: After this certificate ha	Be	25. Was case referred to medical examiner?								of Deat	h (Check only or	ne)				
hysi his c	ျှ	1 ☐ Yes 2 ☐ No	Hospital: 14	Inpatien	t 2 🗆 ER/O	utpatien	t 3 □ DC	DA Oth	er: 4 🗆 Nu	ursing Ho	me 5 Resid	ence	6 □ Other (S	Specify)	
ding Ph h. After th funeral	Ë	27. Manner of Death 1.☐Natural 5 ☐ Pending		of Injury	Year) 28b.	Time of Injury	2	28c. Injur Worl	y at		28d. Describe h	ow inju	ry occurred			
ath.	aţic	1, ☐ Natural 5 ☐ Pending 2 ☐ Accident investig		, Duy,			М		Yes 2	No						
Atte	<u>E</u>	3 Suicide 6 Could r	ot be 28e. Plac	e of Injury	y - At home, fi (Specify)	arm, stre	et, factory	, office			28f. Location (S	treet ar	nd Number o	r Rural	Route Nui	mber,
afte Dire	Certification:	4 ☐ Hornicide determ	build	aing, etc.	(Specify)						City or Tow	n, State	9)			
spita ours neral fille		29a. Certifier 1 Certifyin	g Physician: To th	ne hest of	my knowledo	ne death	occurred	at the ti	me date ar	nd place	and due to the	cause(s	and manne	r ac ct	ated	
To the Hospital or Attendin within 24 hours after death To the Funeral Director. Aft completely filled in by the fur	Medical	(Check only 2 Medical one)	Examiner: On the	basis of e	examination a	nd/or inv	estigation	, in my o	ppinion, dea	ath occur	red at the time,	date an	d place, and	due to	the cause	(s)
the ithin the	Mec	29b. Signature and title of certifier	and IIIa	inioi sidit			200	Licens	e number			204 0-	ite signed (M	onth I	Jav Vonri	
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V	ļ	Willen & Ke	ule	14	Mes			Dar	119	0	/	Aug	ust	ll,.	200	8
	Ī	30. Name and address of person	who completed cau	use of dea								1		7	,200	32
		ARTHUR F. WA	oderno	LVR	34	16	016	100	lwo	od	Ct D	In.	ust d	11	RUL	a wri
Sta	te	31. Date filed (Month, Day, Year)	32		s Signature	1	46						/		/	
Registra	ar	AUG 13	2008	ALLAS.	15.	GOS	sole)									
HMH 17 Rev 1/20	001		19			-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2008

27794

		1 - For State Registrar	State of	Marylan	id / Depa <i>Cei</i>	artment of hartificate of	Health <i>Death</i>	and M	tental Hy	giene Reg. No	20	08	2779
		1. Decedent's Name (First, Middle,	Lest)						2. Date of De	eath			3. Time of Death
Physi /Med		Dorothy Niama Me	edora						Month August	1 0,	^y 2008 [']	'e ar	8:30 p M
Exam		4a. Facility Name (If not institution,	give street and numb	ber)		4b. City, Town, o	r Location	of Death		40	. County of	Death	
		Montgomery General	l Hospital			Olney					Montg	omers	7
Funera Directo		5. Social Security Number 190–12–5542	6. Sex 7 1 □ M 2 ▼ F	. Age (In yrs.	last birthday) 9 Yrs.	If Under 1 Year Months Days	If Unde Hours	Min.	8. Date of Bi (Month, D Aug. 27			Coun	lace (State or Foreigr try) Sylvania
P		Usual Residence of Decedent											
arylau shov	-	10a. State 10b. County		10c. Cit	y, Town or Lo	cation						11	0d. Inside City Limits
Ba-f	Director		ontgomery	Sa	ndy Spri	7							1 □ Yes 21 No
vith th	جَّا	10e. Street and Number				10f. Zip Code				10g. Ci	itizen of Wh	at Coun	try?
s 23	e a	17512 Ashton Gree			0 (10.	20860				USA			
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	12. Was Deceded Armed Force at 1 Tes 2 If Yes, Give Year or Date	es? ⊠No		Vas Decedent of H fYes, specify Cub I □Yes 2⊈ No	an, Mexica	an, Puerto	ecify Yes or No Rican, etc.)	0-	14. Race - Black, Specify: \(\bar{\chi}\)	White, e	etc.
21215-0036 d within 72 hours aft gliene. er than "natural", or the Medical Exami	Completed	15. Decedent's	s Education	- 7	16a. Deced	lent's Usual Occup	pation			16b. K	(ind of Busi	ness/inc	fustry
215 Pin 7	l de	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (1-4	lor 5+)	Give life. L	kind of work done OO NOT use retire	during mo d)	st of worki	ng				
d wit	Ş		2		R∈	gistered N	lurse				Heal	th Ca	ire
al Hy other vent,	Be	17. Father's Name (First, Middle, L	ast)				18. Moth	ner's Name	(First, Middle	, Maider	n Surname)		· - · - · -
/lanuld by Wenta	10	George Hanna					Sara	a Louis	se George	9			
Baltimore, Maryland berine Permit. Pages 1 and 2 should be file Department of Health and Mental Hymportant: If item 27 is marked others by Injury or other traumattc event	ľ	19a. Informant's Name/Relationsh Rosemary Medora/Dau				g Address <i>(Street</i> shton Gree							Code)
St 1 a of Hein item		20a. Method of Disposition	_	20b. P	Place of Dispo	sition (Name of natory or other place	ce)		ate	20c. L	ocation - Ci	ty or To	wn, State
Page nent int: If		1 ☐ Burial 2 ☑ Cremation 3 ☐ Other (Sp		ale		an Cremato		,	gust 12	Ale	xandria	a. Vi	rginia
alti mit. partn porta		21. Signature of Funeral Service L	icensee		22	Name and Addre	ss of Faci	2(908	l			- 9
w gg E E	SUCE	7/1/1/1	Mari	Un		ancis J. C M Universi						0000	
bhysician and Examine and Physician and Examine and Examine and Examine and Examine as the burial-transit	Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Entire Indestrying Cause (Disease or injury that initiated events resulting in death) Last	b. Seption Due to (or Due to (or	espirat ras a consequence Shock ras a consequence dial Infa ras a consequence	uence of):	ure							Onset and Death
Division of Vital Records, P.O. Box 68 or Attending Physician: The law requires that the death certifica sifer death. Director: After this certificate has been signed by the attending phin by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2 ☐ Feta int at time of d	Ideath 3□	Ectopic pregnand	су				23d. Date o		ery Day Ye ar
that	by Pl	Part II. Other significant condition	s contributing to dear	th but not resi	ulting in the ur	derlying cause giv	en in Part	l.	23e. Did	tobacco	use contrib	ute to th	e cause of death?
rds, quires en sign uld be		_Chronic Obstructiv	e Pulmonary	Disease					10	Yes 2	! □ No 3	☐ Prob	ably 4 🔀 Unknown
w requir	Completed		_						24a. Was	an	24h We	re auto	psy findings available
The law	Ĕ				·				auto perfe	psy ormed?	pride	or to cor ath?	mpletion of cause of
ital Flan: The lan: The rifficate stor, page		25. Was case referred to medical					00 81		1 Tes		0 1	Yes	2 🗆 No
Vita /slclan: s certific	o Be	examiner? 1 ☐ Yes 2 XXIIo	Hospital: 100 lps	nationt 2 🗆	ER/Outpatien	Oth			(Check only				
on of V	11-	27. Manner of Death	28a. Date of	Injury	28b. Time of	28c. Inju	4 🗆 ۲		me 5 ☐ Res 28d. Describe				γ)
Division of Vital Records, or attending Physician: The law requires that redeath. Director: After this certificate has been signed in by the funeral director, page 2 should be of	cation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigs 3 ☐ Suicide 6 ☐ Could no	(Month,	, Day, Year)	Injury	M 1	ḱ? Yes 2[ny documed		
Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af	Certification:	4 ☐ Homicide determin	ned 28e. Place of building			eet, factory, office			City or To	wn, Stat	e)		l Route Number,
he Hosp n 24 hou ne Funei pletely fil	Medical	29a. Certifier 1 ☐ Certifying (Check only one) 1 ☐ Medical E	Physician: To the b xaminer: On the bas and manne	sis of examina	wledge, death tion and/or in	occurred at the ti restigation, in my	ime, date a opinion, de	and place, eath occurr	and due to the red at the time	e cause(, date an	s) and man	ner as s d due to	tated. the cause(s)
Z Total company	Ž	29b. Signature and title of certifier	a d	10	,	29c. Licens	se number	90	7		ate signed (Day, Year)
		30. Name and address of person w							1		<u> </u>	,	, 2000
	tate	Aruna Paspula, MD 31. Date filed (Month, Day, Year)		nce Phil gistrar's Signa		e, Olney, I	MD 208	332					
5	tate	NIC 13	2002	, o oigila	20 1	No.							

McElrath

2. Date of Death

10,

2008

Montgomery

4c. County of Death

Month

Aug.

4b. City, Town, or Location of Death

Silver Spring

3. Time of Death

4:25 AM

10d. Inside City Limits

XIXYes 2 □ No

Physician /Medical Examiner

1. Decedent's Name (First, Middle, Last)

Diane

4a. Facility Name (If not institution, give street and number)

Holy Cross Hospital

I.

the burlal-transi Box 68760, P.0. Division of Vital Records, After

5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Funeral Months Days Hours 1 □ M 2 😿 F 40 Director 220-56-4922 10 - 8 - 49Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show the Medical Examiner must be notified at Director MD. Montgomery Colesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 13313 Octagan Lane items 23a 20904 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 **X**No If Yes, Give Baltimore, Maryland 21215-0036 6 Specify: Black 1 ☐Yes 2X No **¾**Widowed 4 □ Divorced Is marked other than "natural", Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Massager 12th 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Himportant: If Item 27 Is marked oth any lipiry or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) Be Roscoe Dorsey Edith A. Thornton ျှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yolanda McElrath/Daughter 13313 Octagan Lane, Colesville, Md. 20904 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 → Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Maryland Nat. Cem | 8/18/08 21. Signature of Funeral Service License ette w. Hacket & 814 Upshur Street, N.W. a. art 1. Inter the disease, or complications that clused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Myocardial Infarction /Medical Due to (or as a consequence of): Examiner End Stage Renal Disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Hospital or Attending Physician: The law requires that the death certificate be executed Congestive Heart Failure

Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 1 Live birth 2 Fetal death 3 🗆 Ectopic pregnancy in the past 12 months? Month 1 ☐Yes 2 ☐ No 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ď Completed 24a. Was an autopsy 1 □Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Certification: To 1 Yes 2 No 1 Monpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation M☐ Natural To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 2 Accident 1 ☐ Yes 2 ☐ No 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined 29a, Certifier Medical (Check only one) 29b. Signature and title of contifier 29c. License number MI D67589 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harold Vincent Lawson Jr., M.D. 1500 Forest Glen Rd. S.S., 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

20c. Location - City or Town, State Laurel, Md. 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc. Approximate Interval Between Onset and Death 23d. Date of delivery Day Year 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No Other: 4 \subseteq Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mariner as stated. 29d. Date signed (Month, Day, Year) 8/11/08 AUG 13 2008 Registra **ORIGINAL**

Domingo Diaz Mercado 08-06160 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No 1. Decedent's Name (First, Middle.Last) 2 Date of Death Physician/ Year Month Day August 12, 2008 **Medical Examiner** Paul Domingo Diaz Mercado 921 br pm 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Talbot 6872 Travelers Circle Easton 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Mexico Days Min. 46 Hours 8/04/1962 Director none XM 2 Usual Residence of Decedent \$m 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Talbot Easton or items 23a or 28a-f show must be notified at once, 1 X Yes 2 No hours after death with the Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33 Aurora Street 21601 Mexico Funeral 11. Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian Black or items Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married Married Yes Mexican White 1 X Yes 2 No specify: tem 27 is marked other than "natural", of traumatic event, the Medical Examiner 3 Widowed Divorced If Yes, Give Year Specify: ð 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 lent of Health and Mental Hygiene. Contractor 6 Construction 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) If item 27 is marked 2121 Job Diaz Carbajal Be Heber Mercado 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chris Nagers/Friend 301 South Aurora Street Easton, Md 21601 Department of Health 20b. Place of Disposition (Name of cemetery, 20a, Method of Disposition 20c. Location - City or Town, State Date or other t crematory or other place) Burial 2 X Cremation Removal from State Chesapeake Crem. 8/22/2008 Beltsville, Md. portant: Other Specify: Dopation 5 re of Funeral Se HYPPIP AGES RETNALDI FUNERAL SERVICE, P.A. 241 Columbia Blvd.Silver Spring, Md20910 e icens 23a. Par I. Ent. If the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Head and chest injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and that the death certificate be executed Physician/Medical #3,23a,27,28a-f, perME, g882 8/29/08 TT X UNPENDED the attending physician led for use as the burial **AMENDED** Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Month Live birth 3 Ectopic pregnancy Day Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? o. þ مَ Yes 2 ✔ No 3 Probably 4 Unknown Completed Records, peen 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed' death? certificate Yes 2 1 V Yes 2 No Physician: 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be Hospital: 1 examiner? Other₄ DOA Nursing Home 5 Residence 6 V Other: Scene Inpatient 2 ER/Outpatient 3 this 1 V Yes No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After 27. Manner of Death 28c. Injury at Work? | 28d. Describe how injury occurred subject fell off roof at work To the Hospital or Attending Certification: Natural Division 1 X Yes 2 Director: d in by the death. Pending 8/12/08 FND 11:00am FND 2**X** Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6872 Travelers Rest 24 hours after 3 Suicide Could not be within 24 hours a To the Funeral I determined Easton, MD Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 7= 0000 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) August 13, 2008 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, 32. Registrar's Signature

State Registrar Day Ya

08-06187 Maurice Powe Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

aurice Powe			ate of Maryla	and / Depa		Health:			giene		008	2779
Physicia	n/	Decedent's Name (First, Middle)	e,Last)					2	Date of Death	1	3. Time of	
ledical Examin		Maurice Powe	<u> </u>		PU				Month August 13,	2008 4c. County of	0805	hrs
		4a. Facility Name (if not institution Laurel Regional Hosp		umber)	Í	Laurel	, or Location of	Death		Prince Ge		
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	last birthday)	If Under 1			8. Date of Birtl		9. Birthplace (Sta Foreign	ite or
Director		N/A	1X M 2 F		Yrs		Days Hours	Min.	June		CountMary	yland
è	ŀ	Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locati	ion				-	10d. Inside	e City Limits
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arylan 3a-f s	Director	10e. Street and Number				10f. Zip Coo	de		10	g. Citizen of Wha	at Country?	
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h with	Funeral	11. Marital Status 1 X Never Married 2 M		cedent Ever in U			f Hispanic Origir Joan, Mexican, F			14. Race - White,	American Indian, etc.	Black,
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72 hou "nai	eted	Elementary/Secondary (0-12)	College (during m	ost of working	life. DO NOT u			1 - 1	,	
5-0036 led within 7 Hygiene. other than the Medica	Comple	0	0		1	J/A			,	N/A	Α	
1215-0036 Id be filed within 72 dental Hygiene. arrived other than event, the Medical		17. Father's Name (First, Middle, Ronald Sumpt	•					,	First, Middle, M Powe	laiden Surname)		
2121 ould be fi	To Be	19a. Informant's Name/Relations			19b. Mailing	Address (S				ber, City or Town	, State, Zip Code)	21403
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shi injury or other traumatic event, the Medical Examiner must be notified at once	٦	Ronald Sumpt		er)							is, Md	
re, l s 1 and f Healt f item cr tra		20a. Method of Disposition 1 X Burial 2 Cremation	2 Pernaval f	20b	Place of Dispos	ition (Name o	f cemetery,		Date	20c. Location -	City or Town, State	е
Pages nent of ant: I		4 Donation 5 Other Sp			emorial	L Park	: 8	3-22			olis, Mo	d.
Baltimore, permit. Pages 1 ar Department of Her Important: If ite injury or other it		21. Signature of Funeral Service	Licensee		10000		Section of the section of			nary, I		
Physician	27	23a. Part I. Enter the disease, or	complications that	aused the death					-	s, Md.		nate Interval
/Medical	77	failure. List only one cause	on each line.					,			Between	Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)		ac arrn a consequence o								
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ps d	Examiner	events resulting in death) Last	Due to (or as	a consequence o	of):							
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60, tre be exe hysician : e burial -	/led	IF FEMALE:		outcome of preg			-			23d. Date of o	telivery	
30x 68760, death certificate be attending physical for use as the burner of the burner at the burner	ian/Me	23b. Was decedent pregnant in the past 12 months?	ne 1 Live	birth	2 Fe	tal death	3 Ectopic	pregnand	су	Month	Day	Year
Box (see death co	Physici	1 Yes 2 No 9 Uni	1 1	nant at time of de	eath 5 Ot	her (Specify)						
D. B it the d by the	F)	Part II. Other significant condit			resulting in the u	ınderlying cau	ise given in Part	t I.	23e. Did to	bacco use contrit	oute to the cause of	of death?
P.O.	d b								1 Yes	2 V No 3	Probably 4	Unknown
Records, The law require	Completed								24a. Was a		ere autopsy findir	
The law ate has age 2 st	E I								perfor	med? de	eath?	No
tal Rection: The certificate	Be	25. Was case referred to medica examiner?				26.F	lace of Death (C	Check on	ly one)			
of Vital ng Physiciam: After this certi		1 ✓ Yes 2 No	Hospital:	Inpatient 2						Residence 6	Other:	
n of oding Pl		27. Manner of Death 1 X Natural 5 Pend		or injury h, Day,Year)	28b. Time of I	· ·	Injury at Work? Yes 2		aa. Describe n	ow injury occurre	ea	
Division tall or Attendiners after death.	icati	2 Accident Inve	stigation 28e Play	ce of Injury - At h	ome, farm, stree				8f. Location (S	treet and Numbe	r or Rural Route N	Number, City
Div pital or ours after teral Dir filled in	ertification:		d not be rmined (Specify,				Ū.	- 1	or Town, S			
Di Hospital 24 hours a Funeral	O	29a. Certifier 1 Certifying P	hysician: To the be									
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beautified in by the funeral director, page 2 should be detached for use as the base of the funeral director, page 2 should be detached for use as the base of the funeral director, page 2 should be detached for use as the base of the funeral director.	Medical	one) 2 Medical Exa	miner: On the basis and manner:	of examination a stated.	and/or investigat			urred at t	he time, date a			
	Σ	29b. Signature and title of certifie	er /	~ .			cense number				d (Month, Day, Ye	ear)
		Janh	gog.	ins			.C.M.E.			August 14,	∠UU8 ———————————————————————————————————	
		30. Name and address of person Tasha Greenberg MD		ise of death (Iten Nedical Exam	*	Penn Stre	et, Baltimore	e. MD	21201			
Sta	ite	•	32. R	evistrar's Signat	ure	_		,				
Registr	rar	31. Date filed (Month, Day, Year) AUG 2	2 2008	There	J. A	revision						

08-06268

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

2008 27799

asmine Queen		State of Maryland / L -For State		ate of De			. No.	00 2117
Physiciar	_	e <u>distrar</u> 1. Decedent's Name (First, Middle,Last)				Date of Death Month	Day Year	3. Time of Death
ledical Examin	er	JASMINE QUI	EEN			August 16,	2008	0407 hrs
	í	4a. Facility Name (if not institution, give street and number) Anne Arundel Medical Center			ity, Town, or Location of napolis	Death	4c. County of Dea Anne Arunde	
E-man-1			n yrs. last bir		Under 1 Year If Under	24Hrs. 8. Date of Birth	(MM/DD/YYYY) g. B	irthplace (State or Foreign
Funeral Director		214-27-9690 _{1 M 2} X _F 20			lonths Days Hours	Min. JULY 2	4, 1988 M	ARYLAND
ı,		Usual Residence of Decedent 10a State 10b County 10	c City Town	or Location				10d. Inside City Limits
ow any		MD ANNE ARUNDEL		CHTON				1 XYes 2 No
Maryland 28a-f show d at once.	홠	10e. Street and Number		101	f, Zip Code	10	g. Citizen of What Co	untry?
he Ma or 28	Director	1206 DELAWARE AVENUE		4	20733		USA	•
		11. Mantal Status 12. Was Decedent Ev	er in U.S.	13. Was De	cedent of Hispanic Ong	in? (Specify Yes or No-	14. Race - Ame White, etc.	erican Indian, Black,
death ritem	Funeral	1 Never Married 2 Married Armed Forces? 1 Yes 2	ζ _{No}	if Yes, s	pecify Cuban, Mexican,	Puerto Rican, etc.)		
after	ă-	3 Widowed 4 Divorced If Yes, Give Year or Dates:			2 X No specify:		Specify: B	LACK
hours hatur	등 -	15. Decedent's Education (Specify only highest grade complete Elementary/Secondary (0-12) College (1-4 or 5+)			sual Occupation (Give k of working life, DO NOT of		Tob. Kind of business	5/maustry
5-0036 led within 72 hor tygiene. other than "na the Medical Ex	Completed	2 YRS		STUDEN	Γ		PRIVATE	
5-003 iled within Hygiene. I other th	탉	17. Father's Name (First, Middle, Last)				s Name (First, Middle, M	aiden Surname)	
21 21 be fill latal lated cut,	8	EDWARD N. QUEEN JR.				ESA HAMILTO		
bould hould is ma	ို	19a. Informant's Name/Relationship (Type, Print)				ber or Rural Route Num NUE CHURCHT		
e, MD 2 I and 2 shoul Health and N Fitem 27 is in re traumatic	-	THERESA MAPP/MOTHER 20a. Method of Disposition			(Name of cemetery,	Date Date	20c. Location - City	
nore ages 1 a nt of He nt: If it		1 Burial 2 Cremation 3 Removal from State	crema	atory or other p	place)	0/15/2009	TAUDET M	ADVI AND
tim Pag	-	4 Donation 5 Other Specify: 21. Signature of Fuhriral Secret. Licensee	MD N		L CEMETERY and Address of Facility	8/25/2008	KINS FUNE	
Baltimore, permit. Pages 1 an Department of Hea Important: If itel injury or other tra	7	21. Sglate of Farial of Electron				OAD LANDOVE		
Physician	4	28a. Part I. Enter the disease, or complications that caused the	e death. Do i	not enter the m	node of dying, such as ca	ardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a. Pulmonary	thromb	oembol	ism			Death
Adminier		or condition resulting in death) Due to (or as a consequence to the conditions of t		ocic				7
	اة ا	Sequentially list conditions, if any, leading to immediate b. deep vein Due to (or as a consequence)		0212				
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated Underlying Cause) Due to (or as a consequence of the consequen						
ecuted and - transit	Exa	events resulting in death) Last	,					
execuian an	Medical	X UNPENDED AMENDED PI 1	ine a-	b, PII	,27,perME,	g883 9/11/0	J8 TT	
760, cate be exe physician 8 he burial -	ĕ	IF FEMALE: 23c. If yes, outcome	of pregnanc				23d. Date of deliv	The same of the sa
Sox 687(death certifica e attending pl	ian/	23b. Was decedent pregnant in the past 12 months?	ne of death	2 Fetal of		c pregnancy	Month	Day Year
Box 687 e death certific the attending p ed for use as th	Physician/	1 Yes 2 No 9 V Unknown 9 Unknown		5 Other	(Specify)			
O. Bat the d	P.	Part II. Other significant conditions contributing to death b			erlying cause given in Pa			to the cause of death?
s, P.(ed by	Obesity; oral contracepti	ve use	3				Probably 4 V Unknown
cords,	Completed					24a. Was autop		autopsy findings available to completion of cause of
Rec The la cate ha	E					1 Yes		
Division of Vital Records, P.O. In or Attending Physician: The law requires that it is after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	Be	25. Was case referred to medical examiner?			26.Place of Death Other			
F Vil Physic er this	의	1 V Yes 2 No		Outpatient 3 Time of Injur			Residence 6 Ot	her:
n of Inding Ph. h.: After t	<u>:</u>	27. Manner of Death 1 X Natural 5 Pending 28a. Date of Injury (Month, Day,Yea	r)	(1 Yes 2		. ,	
isio	icat	2 Accident Investigation 28e, Place of Injur	y - At home,	farm, street, fa	actory, office building, et			Rural Route Number, City
Division pital or Attencours after death reral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify)				or Town, S	itate)	
Hosp 24 hor Fune rely fi		29a. Certifier 1 Certifying Physician: To the best of my	nowledge, d	leath occurred	at the time, date and pla	ace, and due to the caus	e(s) and manner as s	stated.
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical	one) 2 Medical Examiner: On the basis of examinand manner stated.	nation and/o	r investigation,		ccurred at the time, date		
	Σ	29b. Signature and title of certifier			29c. License number		29d. Date signed (
		Mel aux mo			O.C.M.E.		August 16, 20	
10	ſ	30. Name and address of person who completed cause of dea Russell Alexander MD. Assistant Medical			enn Street, Baltimo	ore, MD 21201		
Sta	ate			مر		.,		
Regist	rar	31. Date filed (Month, Day, Year) AUG 2 5 2008	K Ap	ME!			OCME	
DHMH 17 Rev 1/20 OCME 2006	01		0	RIGINAL				

			1 - For State Registrar	State of M	larylan		artment rtificate			and M	lental Hy	_	1e 1o. 2008	27	800
	Physici	an	Decedent's Name (First, Middle, La.	st)							Date of De Month		ay Year	3. Time of	
	/Medi			O MARY RI							AUG	8	2008	1:57	P M
1	Examir	ner	4a. Facility Name (If not institution, given NATIONAL NAVAL N				4b. City, To					4	lc. County of Death	(TDI)	
	Funeral		5. Social Security Number 6. S			last birthday)	If Under 1		IESDA If Under 2		8. Date of Bi	rth	MONTGOM 9. Birthp	lace (State o	r Foreian
n	Director		254-82-3257	□M 2 X F	79	Yrs.	Months	Days	Hours	Min.	(Month, Da		r) Coun 1928 Japan	itry)	, r or org.
	pc _		Usual Residence of Decedent		T40 0"										
	aryla show	=	10a. State 10b. County			y, Town or Lo	cation						1	0d. Inside Cit 1 ☐ Yes	
	the M 28a-f otifie	Directo	Virginia Fairfax 10e. Street and Number		Burl	ke	406 75- 6	\ - d -			1	10- (Citizen of What Coun		220 110
	with a or		6315 Falling Brook	Dreisso			10f. Zip C					•		,	
	ns 23 mus	Funeral	11. Marital Status	12. Was Decedent	t Ever in U.	S. 13.			spanic Orio	gin? (Spe	ecify Yes or No Rican, etc.)		ited State 14. Race - Americ		
9	after or iter		1 ☐ Never Married 2 🔀 Married	Armed Forces	? (No					i, Puèrto	Rican, etc.)		Black, White,	etc.	
93	72 hours after death with the Maryland natural", or items 23a or 28a-f show dikal Examiner must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2l	ANO	Specify:				Specify: Asia	ın	
Maryland 21215-0036	d within 72 ho giene. Ir than "natu the Medical	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)		16a. Dece	dent's Usual kind of work DO NOT use	Occupa done d	ition u <i>ring most</i>	of work	ing	16b.	Kind of Business/Ind	dustry	
12	within iene. than " he Mec	E G	Elementary/Secondary (0-12)	College (1-4or	5+)	ĺ		retired)					77		
d 2	Hygie Hygie ther ont, th		17. Father's Name (First, Middle, Last)	Т		поте	Maker		18. Mothe	r's Name	e (First, Middle		n Home		
an	ould be Mental arked o	To Be	Shinichi Isoda								awaki	,	- ,		
ary	shou nd M mar	-	19a. Informant's Name/Relationship (Type. Print)		19b. Mailir	ng Address (Street a	nd Numbe	r or Run	al Route Numb	er, City	or Town, State, Zip	Code)	
ž	s 1 and 2 of Health a item 27 is other tra		Edward C. Rish, Hu	ısband		6315 Burke	Falli VA	1901 2201	rook 5	Dri	ve				
Baltimore,			20a. Method of Disposition 1 ☐ Burial 2 ACremation 3	Pamoval from State		lace of Dispo	sition (Name	of er place			st 13,	20c.	Location - City or To	wn, State	
Ĕ	Pages ment of lant: If its		4 □ Donation 5 □ Other (Specify		Fai Fur	rfax l eral l	demori dome	al		2008	JC 13,	Fai	irfax, Vir	ginia	,
3ali	permit. Page Department of Important: If any injury or once.		21. Signature of Funeral Service Licer			22 F2	Name and	Address	of Facility	у 1 Fu	neral H	Home	1		
	40 = 16 O	_	Brunn M ² 23a. Part1. Enter the disease, or com		M015								VA 22032	Approximate	
8760,	Physician /Medical Examiner physician and physician and the pruial-transit the prior of the prio	al Examiner	Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Uniteract or highly that initiated events resulting in death) Last	a. Due to (or as b. Due to (or as c. Due to (or as	s a co ns equ	uence of):									
P.O. Box 6	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 ☐ Fetal at time of de	Ideath 3E eath 5E	Ectopic preg Other (spec	cify)	n in Part I.		23e. Did	tobacco	23d. Date of delive Month	Day Y	eath?
ğ	equire en sig ould b										1 🗆	Yes	2 No 3 □ Prob	ably 4 □U	Inknown
or Vital Records,	The larate has	Completed									24a. Was auto perfe 1∐ Yes	psy ormed?	death?	npletion of ca	vailable use of
<u>≅</u>	Attending Physician: Thr death. ector: After this certificate by the funeral director, pag	Be	25. Was case referred to medical examiner?	Hospital:				-		of Death	Check only	one)			
ō	Phys rthis ral dir	. To	1 ☐ Yes 2 No 27. Manner of Death	28a. Date of Inj		ER/Outpatier 28b. Time o			4 LI NUI				6 □Other (Specify	y)	
o	dlng h. Afte fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Da	ay Year)	Injury	м	lnjury Work' 1 □ Y	?ື່ es 2.∐.N		28d. Describe	now III	jury occurred		
Division	in Pire	Certification:	3 Suicide 6 Could not be determined	28e. Place of in	jury - At ho tc. <i>(Specif</i>)	me, farm, str	eet, factory,				28f. Location (City or To	Street wn, Sta	and Number or Rura afe)	l Route Numi	ber,
	the Hospital in 24 hours a the Funeral I	Medical ((Check only 2 Medical Exam	ysician: To the best niner: On the basis of and manner si	of examinat	wledge, deatl tion and/or in	o occurred at vestigation, i	the tim	e, date an inion, dea	d place, th occur	and due to the red at the time	cause , date a	(s) and manner as si and place, and due to	tated. the cause(s))
	To the within 2 To the complet	Σ	29b. Signature and title of ortifier						number			29d. [Date signed (Month,	Day, Year)	
	V			- 1P	0		01	022	01805				Hug 2	SUS	
				MC USN			Print)				L NAVAL A MD 20			TER	
	Sta Registr	-	31. Date filed (Month, Day, Year) AUG 1 3 2008	32. Regist		ture	E)								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** Day /tugust 4:12 AM T. Reynolds James 11 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington County Hospital Hagerstown Washington If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) Funeral Months Days 5, 220-34-9107 Director 67 Oct. 1940 Georgia Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location show Item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Invalidation Director 1 ☐ Yes 2X No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21742 122 Sunbrook Lane IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. within 72 hours after 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 □Yes 2 🔣 No If Yes, Give Year or Dates: ģ Specify Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) 10 Pressman Printing permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Judge Henry Reynolds Ella Leona Gurley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Urso/Sister 8424 Skyview Drive, #102, Alexandria, VA 22309 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 15 Parklawn Memorial 4 ☐ Donation 5 ☐ Other (Specify) 2008 Rockville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Cancer disease or condition resulting in death) /Medical Due to or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Cusease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine requires that the death certificate be executed physician and s the burial-trans Due to (or as a consequence of): Box 68760. Physician/Medical use as attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) P.0. the 1 ☐Yes 2 ☐ No 9 Unknown s been signed by the should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Probably 4 Unknown Milmanary Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a. Was an diseas this certificate has page 2 autopsy 1 ☐ Yes 2 No Hospital or Attending Physiclan: 24 hours after death. 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☑ DOA မှ After the funeral 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide e Funeral C 29a. Certifier La Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

Division of Vital Records, မှ

Registra

within 7 the (Check only one)

29b. Signature and title of certifier

MO

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

058191

29d. Date signed (Month, Day, Year)

August 11, 2008

Ray 68760 PO Division of Vital Records.

			Type or Prin			delible Ink. artment of F			_	ile.	
	•	1 - State Registrar		,	•	rtificate of		_	Reg. No. 20	08	27802
Physici /Medic		1. Decedent's Name (First, Middle, Las		STON	IEV			2. Date of Dea	Day	Year 08	3. Time of Death
Examin Funeral Director		4a. Facility Name (If not institution, give 602 Wayward Dr. 5. Social Security Number 6. S		e <i>(In yrs. last b</i>	<i>irthday)</i> Yrs.	,	r Location of Death Polis If Under 24 Hrs. Hours Min.	8. Date of Bird (Month, Pa 4/15/1	4c. County of Anne	Arun	place (State or Foreign ntry)
aryland show	'n	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tov						1	0d. Inside City Limits 1 ☐ Yes 2 🖾 No
with the M a or 28a-f be routifie	Director	Maryland Anne Aru 10e. Street and Number 602 Wayward Dr.	ındel	A	nna	polis 10f. Zip Code 214	01	1	10g. Citizen of W		
perfull Design of the Marylania C. 12.13-0030 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examiliar must be multified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 ☑ Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 MYes 2 N If Yes, Give Year or Dates:	No		Was Decedent of H If Yes, specify Cuba 1 □Yes 2 ☒ No		pecify Yes or No Rican, etc.)		- Americ k, White,	
hin 72 hou e. an "natura Medical E	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Seçondary (0-12)	ucation	16	a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired	during most of work d)	sing	16b. Kind of Bu		
Idilio Z.I.	To Be Con	12th 17. Father's Name (First, Middle, Last) Albert Blair		,	Sta	ff Sergea	nt 18. Mother's Nam Helen A		U.S. Ar		
and 2 shoule and 2 shoule and 2 shoule and 1		19a. Informant's Name/Relationship (60	ng Address <i>(Street</i> 2 Wayward	Dr., Ann	apolis,	MD 2140)1	
dittillore mit. Pages 1 partment of P portant: If Ite y Injury or ot		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	1)	1	tera	osition (Name of matory or other place ans Cemet	ery 8-14		Crownsv	ille	e, MD
Depariment of the policy of th		21. Signature of Pupera/Service Licer				2. Name and Addre	mons Isla	nd Rd.	Edgewate		ID 21037
Physician		23a. Part 1. Enter the disease, or come shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. MW	a stat	lic	0 4	Carcino Carolado	1	inknown	<u> </u>	Approximate Interval Between Onset and Death Walley
Examiner and transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b	a consequence	Pn e of):	imary	Side	<i></i>			
ficate be ex physician as the burial		l	d.	a consequence	e oi).					_	
To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a 9 ☐ Unknown	2 Fetal dea		☐ Ectopic pregnand ☐ Other (specify) _	су		23d. Date Mor		ery Day Year
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hysicia hysicia nis cert directe	To Be	examiner?	Hospital: 1 ☐ Inpatie	ent 2 ER/0	Outpatie	nt 3 DOA Oth	26. Place of Dea ner: 4 Nursing H	1.1	idence 6 □Oth	er (Spec	ify)
ending Ph eath. or: After th he funeral	Certification:	27. Manner of Death 1		ary 28b	. Time o	Wor	ry at k?]Yes 2 □ No	28d. Describe	how injury occurr	эd	
DIVISION Att		4 Homicide determined	building, et	c. (Specify)		reet, factory, office		City or To			
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the tu	Medical		ysician: To the best niner: On the basis of and manner st	of examination			opinion, death occu			and due t	to the cause(s)
(Xal)	5	> Michael of	Hen	tum	\ /T-==	D	V/43	8	Hu		J 12,2008
Str	ite.	30. Name and address of person who MICHAEL J. La 31. Date filed (Month, Day, Year)	S2. Restr	rar's Signature	44 4	DEFEN	USE H	6HWA	y Haw	APUL	MDUYOI
* Registr		AUG 1 3		we d	×	parke					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician STOCK WELL 2000 M ARIUN 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth (Month, Day, Yea 3/4/1917 7. Age (In yrs. last birthday) **Funeral** Birthplace (State or Foreign Country) Days Hours Year) Months Min 1 M 2 M Director 434-62-2938 91 Michigan Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at Director 1 ∐Yes 2 🕅 No Maryland Anne Arundel Annapolis Pages 1 and 2 should be filed within 72 hours after death with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 974 Riversedge Circle 21401 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify White ò Specify: 3 Widowed 4 Divorced Completed 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "ampi rigury or other traumatic event, the Magnee. Elementary/Secondary (0-12) College (1-4or 5+) Medical Technician years Health Care 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ray C. Huff Doris Wheeler မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nelson B. Stockwell/ Husband 974 Riversedge Circle, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 M Cremation 3 ☐ Removal from State Kalas Crematory 4 ☐ Donation 5 ☐ Other (Specify) 8/13/08 Edgewater, MD 21. Signal Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home VILL 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last ner Due to (or as a consequence of): sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Exami Due to (or as a consequence of): P.O. Box 68760, attending physician Physician/Medical as the nse 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery for 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗖 No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) ed by the 9 Unknown 9 ☐ Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate 1 □Yes 2 No 1 ☐ Yes 2 ☐ No After this certific funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after deatl To the Funeral Director: filled in by the 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only 29b. Signature and title of certifier 29c. License number Name and address of person hpleted cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

AUG 13

32

gistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

		-	For State Registrar	State of Marylar		ertificate of De			g. No.	8 27804
	Physicia	an	1. Decedent's Name (First, Middle, Las	۵,	5000	-110		2. Date of Death Month	Day Year	3. Time of Death
	/Medic	al 🗵	4a. Facility Name (If not institution, give	street and number)	# 10	4b. City, Town, or Lo	ocation of Death	Huly	9 200 4c. County of Dea	<u> </u>
			785C Ameri 5. Social Security Number 6. Se	CANA CITE	lost hirther	If Under 1 Year II	BUY f Under 24 Hrs.	8. Date of Birth	1 9 Bi	inthplace (State or Foreign
	Funeral Director		220-29-4909	MM 2□F 24	Yrs.		Hours Min.	(Month, Day, 12/13/1	Year) C	ryland
	yland Iow at		Usual Residence of Decedent 10a. State 10b. County	10c. Ci	ity, Town or	Location				10d. Inside City Limits
	e Mar sa-f sh tifled	ctor	Maryland Anne An	rundel (>/en	Burnie	2			1 □Yes 2 No
	3a or 28	Funeral Director	7856 Ameri	eand irde	# 10	10f. Zip Code 3 2/06	٥	10	ig. Citizen of What C USA	Country?
	ems 2	iner	11. Marital Status	12. Was Decedent Ever in U Armed Forces?	J.S. 1	3. Was Decedent of Hisp If Yes, specify Cuban,	anic Origin? (Spec Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Am Black, Wh	
0000	ges 1 and 2 should be filed within 72 hours after death with the Maryland tt of Health and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	by Fu	1 ☑ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 □ Yes 2 ☑ No If Yes, Give Year or Dates:		1 ☐ Yes 2 🏋 No	Specify:		Specify: W	hite
2-0	"natur	Completed by	15. Decedent's Ed (Specify only highest gra		(G.	cedent's Usual Occupation ve kind of work done during DO NOT use retired)	on ring most of workin		16b. Kind of Busines	s/Industry
7	within iene. than the Me	dwo	Elementary/Secondary (0-12)	College (1-4or 5+) l year		hift Manage	r		Starbucks	Coffee
2	other Jent, tl	Be C	17. Father's Name (First, Middle, Last)				8. Mother's Name	(First, Middle, N	Maiden Surname)	
/land	ould be Mental arked o	To E	Anthony Tho	mas Scoglio					tte Bell	
Mar	nd 2 allth a 27 Is r tra		19a. Informant's Name/Relationship (Tanthony T. Scog1:			ailing Address <i>(Street and</i> 1A Oak Driv				, Zip Code)
ore,	permit. Pages t a Department of Hea Important: If item any Injury or othe		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐		Place of Dis	position (Name of rematory or other place)		ate	20c. Location - City of	or Town, State
baltimor	permit. Pages Department of I Important: If it any Injury or o		4 □ Donation 5 □ Other (Specify) Mt	. Zio	n Church Cer			Lothian,	-
מם	permit. Pa Departmer Important: any Injury once.		21. Signatur and under Service Licer	isee		22. Name and Address 2973 Solom		_		
	a 5		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the dea	ath. Do not					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a 1.5	nhy	VIA				Onset and Death
d.	/Medical Examiner		resulting in death)	Due to (or as a cons-	quence of	100				
	, light care in	er	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a conse	equence f):	NY				
	outed id	Examiner	Sequentially list conditions, if any, leadin, to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	C						
Ď,	icate be executed physician and s the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):					
08/00	tificate be executed g physician and as the burial-transit	edical		d	-					
ROX	th certif		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome pf pregr 1☐Live birth 2☐Fe		3 □Ectopic pregnancy			23d. Date of o	delivery Day Year
o.	w requires that the death cer been signed by the attendin should be detached for use	Physician/IV	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnant at time of 9□Unknown	death	5 Other (specify)				
<u>ა</u>	requires that een signed b rould be deta	by	Part II. Other significant conditions of	contributing to death but not re	esulting in th	e underlying cause given	in Part I.	23e. Did tol	* A	to the cause of death? Probably 4 □Unknown
Hecords,	v requi	eted						24a. Was a		autopsy findings available
_	sician: The law r certificate has be irector, page 2 sh	Completed						autops	sy prior t med? death	to completion of cause of
VItal		BeC	25. Was case referred to medical examiner?				26. Place of Death			
0	Physician: r this certific ral director,	ို	1 X Yes 2 No 27. Manner of Death	Hospital: 1 ☐ Inpatient 2 [ER/Outpa	tient 3 DOA Other:	4 L Nursing Hor		ence 6 Other (S	pecify)
	or Attending Physician: after death. Director: After this certific in by the funeral director,	Certification:	1 □ Natural 5 □ Pending 2 □ Accident investigation	(Month, Day Year)	Inju	ry Work?	es 21 X ÎNo	1-1 cm	ng Hi	mself
DIVISION	Attending ar death. rector: Afte by the fune	ifica	3 Suicide 6 Could not be determined		home, farm			28f. Location (Si City or Town	treet and Number or n, State	Rural Route Number,
5	iltal or irs afte ral Dir lled in	Cert		Home				GIEN	Bur	we mo
	To the Hospital or Atter within 24 hours after des To the Funeral Directo completely filled in by th	ledical	29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example 1	nysician: To the best of my ki miner: On the basis of exami and manner stated.	nation and/o	eath occurred at the time r investigation, in my opi	e, date and place, i inion, death occurr	and due to the d red at the time, o	date and place, and d	due to the cause(s)
	To th withir To th	Me	29b. Signature and title of certifier	DD.	epie	29c. License	number O605	3-4 2	29d. Date signed (Mo	onth, Day, Year)
	0 RA		30 Name and address of person who	completed pause of death (Ite	em 23a) (Ty	pe, Print)	O60s Amer		0 / 1	-100
	Has		William P.	JONES, 6	n D	695 1	Ther	LCA	21033	5
	Sta Regist		31. Date filed (Month, Day, Year) AUG 1 3	32. Recetrar's Sig		porte				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician James E. Sollers 2008 RUGUST /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSPITAL N/A AGNES BALTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Mar 20 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 1938 **Funeral** Days Months Hours Min. 212-36-9817 1**У** М 2 □ F 70 Yrs. Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 7 is marked other than "natural", or Items 23a or 28a-f shov traumatic event, the Medical Ex-miner must be notified at 1 ☐ Yes 2 No Maryland Anne Arundel Lothian Director 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 20711 USA 154 B Street Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ XNo Specify. Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Prince George's Co. Elementary/Secondary (0-12) College (1-4or 5+) Board of Education Custodian 11th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Sollers Mary E. Smith 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20711 Elsie Sollers(Wife) 154 B Street Lothian, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 M Burial 2 □ Cremation 3 □ Removal from State Moses Cemetery 8-16-08 Lothian, Md. 4 Donation 5 Other (Specify) Manual August of actions Mortuary, P.A. 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. 21401 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 10 DAYS **Physician** SEPTICEMIA /Medical Due to (or as a consequence of) **Examiner** ISCHEMIC CARDIOMYOPATHY if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence or) MALNUTRITION Due to (or as a consequence of): DEBILITATION Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Vear Day in the past 12 months? 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9□ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ENCEPHALD PA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed MULTI ORGAN FRICURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification; To 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury

Records, P.O. Box 68760, Division or Vital

SAME

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burial-transit physician the attending pl signed by the a page 2 should certificate Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifica director,

show

within 24 hours after To the Funeral Di completely filled in Medical the

State

Registrar DHMH 17 Rev 1/2001

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of cortifier

P20659

1 ☐ Yes 2 ☐ No

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and ddress of person who com se of death (Item 23a) (Type, Print)

AUL 31. Date filed (Month, Day, Year) ON CATEN AVE. BOTTOME MO ZING

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

M

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

2 Accident

3 ☐ Suicide

29a. Certifier

4 | Homicide

6 ☐ Could not be

determined

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Dorothy W. Sullivan 12:57 a M August 14, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Hospice Dove House 8. Date of Birth (Month, Day, Oct 13, If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday, 9. Birthplace (State or Foreign **Funeral** Hours Months Days 1 □ M 2 K F Mary Yand 74 218-32-7233 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notifled at 1 ☐ Yes 2 No Westminster Carroll Director Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21157 335 Hook Road USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc. 72 hours after 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates: 1 Never Married 2 Mamed Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify Specify: white چ و 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within ; th and Mental Hygiene. 7 is marked other than "r filed within 7 Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Medical Registered Nurse 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Helen S. Fowble Wilmer B. Whittington ပ permit. Pages 1 and 2 sh.
Department of Health and Important: If item 27 is ma 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 335 Hook Road, Westminster, MD 21157 Arthur H. Sullivan III, husband 20b. Place of Disposition (Name of Scandilly, crematory or other place)
Carroll Crematory Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 8/15/2008 Winfield, MD 4 Donation 5 Dother (Specify) 22. Name and Address of Facility Myers-Dury raw Funeral Home 21. Signature of Funeral Service License . tou 91 Willis Street, Westminster, MD 21157 23a. Park. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on ach line. Approximate Interval Between Onset and Death PONTINE AND BLAIN STEM CEREBROUNCH Immediate Cause (Final 4 dery **Physician** UTE disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence on Examiner use as the burial-trans and Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 💆 No Month Day Year 5 ☐ Other (specify) been signed by the should be detached 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 | Yes 2 No 3 | Probably 4 | Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 performed? Yes 2 No this certificate 25. Was case referred to medical examiner? director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: All completely filled in by the fur 1 ☐ Yes 2 ☐ No death. 2☐ Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 31666 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 261 Costlica STOWER AVENUE Liesning sten mticalopi THONKS K 121 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar AUG 1 4 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1		epartment of Health and N Certificate of Death	Reg. No. 2008 278 [
Physiciar /Medica Examine		1. Decedent's Name (First, Middle, Last) Gary Nelson Smith Ia. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	2. Date of Death Month Day Year 3. Time of Death August 11, 2008 5:40 a 4c. County of Death Montqomery
Funeral Director		Holy Cross Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birt) 220-52-1686 1₺ м 2□ F 46 Usual Residence of Decedent	hday) Silver Spring Hday) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or For Country) Aug. 10, 1962 Washington,
21215-0036 d within 72 hours after death w glene. er than "natural", or items 23a , the Madical Examinar must.	Completed by Funeral Director	10e. Street and Number 10212 Haywood Drive 11. Marital Status 1 Never Married 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) 10212 Haywood Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	ver Spring 10f. Zip Code 20902 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 Yes 2 No Specify: Decedent's Usual Occupation (Give kind of work done during most of wor life. DO NOT use retired) Furniture Repairs	o Rican, etc.) Black, White, etc. Specify: White 16b. Kind of Business/Industry
Maryland 2' nd 2 should be filed w th and Mental Hygie 27 is marked other t traumatic event, In	mi P₋	Nelson Arthur Smith 19a. Informant's Name/Relationship (Type. Print) 19b	Mailing Address (Street and Number or Re	raldine Frances Hurtt ural Route Number, City or Town, State, Zip Code)
Baltimore, Mapernit. Pages 1 and 2 Department of Health a Important: If item 27 is any injury or other transcribe.			gton National Metary 22. Name and Address of Facility Francis J. Colling	Date 20c. Location - City or Town, State 20c. Suitland, Maryland Suitland, Waryland Suitland, Waryland Wd, W., Silver Spring, MD 20c.
Py60, Cate be executed with Examiner the burial-transit	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Sepsis Due to (or as a consequence Diabetes Melli Due to (or as a consequence of Diabetes Melli Due to (or as a consequence of Diabetes Melli Due to (or as a consequence of Diabetes Melli Due to (or as a consequence of Diabetes Melli)	of): Infection of): tus	days months
the death certifice the attending phy the attending phyched for use as the	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown	n 3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	23d. Date of delivery Month Day Yea
Records, The law requires that has been signed age 2 should be d	Completed by	Part II. Other significant conditions contributing to death but not resulting Glioma, Brain		23e. Did tobacco use contribute to the cause of deat 1 Yes 2 No 3 Probably 4 Unk 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
Division or Attending a er deah. Director Afte	Certification: To Be		utpatient 3 DOA Other: 4 Nursing Time of Injury M Nursing M 28c. Injury at Work? 1 Yes 2 No	eath (Check only one) Home 5 ☐ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number City or Town, State)
To the Hospital or within 24 hours a le To the Funeral Dir completely filled in	Medical C	29a. Certifier (Check only one) 1 ☐ Certifying Physician: To the best of my knowledge and title of certifier 2 ☐ Medical Examiner: On the basis of examination and manner stated.	ge, death occurred at the time, date and pla ind/or investigation, in my opinion, death oc 29c. License number	29d. Date signed (Month, Day, Year)
		Yalunga Mp	D32332	August 12, 2008

/Medical Examiner

physician a: the burial-t Box 68760 as Ö σ. i Director: A

Division of Vital Records, within 24 hours a

To the Funerai I

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** 2:45 p M Eleanor A. Sargent August 12, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Clifton Woods Group Home Silver Spring Montgomery 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours Min. 1 M 2 F Director 214-26-4295 96 November 21,1911 Massachusetts Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f show permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Evantmer must be notified at once. 1 ☐ Yes 2 X No Funeral Directo Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15107 Interlachen Drive, #618 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ∐Yes 2 If Yes, Give 2 🔀 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify. \$ 3 X Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Elementary School Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ၀ Hyman Aisner Martha Wall 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Sargent - Son 1800 Old Meadow Road, Unit 1503, McLean, Virginia 22102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 X Removal from State King David Memorial Gardens 08/14/2008 4 Donation 5 Other (Specify) Falls Church, Virginia 22. Name and Address of Facility
Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee fares 11800 New Hampshire Avenue, Silver Spring, Maryland 20904 23a. Part . Enter the dise are or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure dist only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Acute Myocardial Infarction Sudden resulting in death) Due to (or as a consequence of) Coronary Artery Disease Years Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be execute Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month Day Year 5 Other (specify) I∐Yes 2XNo 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown Atrial Fibrillation Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Dementia autopsy 1 ☐ Yes 2 🕱 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 AOther (Specify) Assisted Living Hospital: 1 Yes 2 **X** No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 I Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D32332 August 13, 2008 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9801 Georgia Avenue, #220, Silver Spring, Maryland 20902 Suresh K. Gupta, M.D., 31. Date filed (Month, Day, Year) 32 egistrar's Signature State 14 2008 AUG Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		-	For State Registrar	State of Maryland	d / Depa <i>Cei</i>	artment of l rtificate of	Health and <i>Death</i>	Mental Hy	giene) (Reg. No.	008	27809
			1. Decedent's Name (First, Middle, Last)					2. Date of De Month	Day	Year	3. Time of Death
	Physicia /Medic	_	Cresia A	. Smith		r		08	13	2008	3:30 A M
	Examin	_	4a. Facility Name (If not institution, give s				or Location of Dea	ath		unty of Death	
-oli			Gladys Spellman 5. Social Security Number 6. Sex			Hyatt	sville	S. B. Date of Bi			eorges
	Funeral Director			M 242 F 62	Yrs.	Months Days		8. Date of Bi (Month, Da 09-28	y, Year) -1945		place (State or Foreign Intry) D.C.
	_		Usual Residence of Decedent								
	show		10a. State 10b. County		r, Town or Lo	ocation					10d. Inside City Limits 1√2 Yes 2 □ No
	Ba-f s	cto	MD Prince	Georges U	pper	Mar1bon	0		10- 01	of What Cou	
	vith th	Die.	10e. Street and Number	1 - D 3		10f. Zip Code 2 0 7	770			USA	mu y r
	eath v	erai	9804 Rosaryvi1	12. Was Decedent Ever in U.:	S. 13.	Was Decedent of	Hispanic Origin?	Specify Yes or N		Race - Ameri	
′0	within 72 hours after death with the Maryland ane. then 'naturel', or iteme 23a or 28a-f show ha Marigal Examiner mast be milliad at	Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		If Yes, specify Cu	ban, Mexican, Pue	erto Rican, etc.)		Black, White	
036	el', o	[요	3 ☐ Widowed 4 ऒॗDivorced	If Yes, Give Year or Dates:		1 □ Yes 2 € Mo	Specify:		Sp	ecify: 13	lack
5-0	72 hg	etec	15. Decedent's Edu (Specify only highest grade	cation e completed)	(Give	dent's Usual Occu	a durina most of w	orking	16b. Kind	of Business/Ir	ndustry
21215-0036	hen.	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	-	DO NOT use retir	*		Priv	ate I	ndustry
d 2	Hygie ther I		17. Father's Name (First, Middle, Last)		oust	Omer o		ame (First, Middle	1		
Maryland	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene . Item 27 is marked other then "naturel", or Iteme 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	To Be	George Allen				Ruth	Mitche	11		
ary	shou mar umar	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Maili	ng Address (Stree	t and Number or	Rural Route Numb	oer, City or To	own, State, Zi	ip Code)
	Health a tem 27 is		Kenton Smith (S		Upp	er Mar	lboro,	Road Marylan	d 2	0772	
Ore	of He		20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ F	20b. P	lace of Dispo emetery, cre	osition (Name of matory or other pi	ace)	Date	20c. Locat	tion - City or T	
Ĕ	Pag ment ent: I		4 ☐ Donation 5 ☐ Other (Specify)	Ft		coln Ce		-18-200			
Baltimore,	permit. Pages 1 an Department of Heal Importent: If Item 2 eny injury or other once.		21. Signatur of Funeral Service Lean		436 R	2. Name and Add alph W: 813 Pot	ess of Facility 1111ams comac A	Funera ve.,SE;	1 Ser Wash	vice ., D.	C. 20003
			23a. Part1. Enter the disease, or compleshock, or heart failure. List only or	ications that caused the death ne cause on each line.	h. Do not en	ter the mode of dy	ring, such as card	ac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Metastat	ic Br	east Ca	ancer				511001 4110 504111
1	/Medical Examiner		resulting in death)	Due to (or as a consequ	uence of):						
		2	Sequentially list conditions,	Dua to (or as a conseq	rienga of):						
	nted Insit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
Ć.	exection and ial-tra	Exa	that initiated events resulting in death) Last	Due to (or as a consequent	uence of):						
8760,	cate be executed by sicien and the burial-transit	dicai		d							
9	certifica nding ph use as th	Med	IF FEMALE:								
Box		Completed by Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta	I death 3	□Ectopic pregnan	су		230	 Date of deliment Month 	ivery Day Year
0.	0 0	ysic	1 □ Yes 2 □ No 9 □ Unknown	4 Pregnant at time of d 9 Unknown	eath 5	Other (specify)					
α.	equires that the death sen signed by the atte tould be detached for	P.	Part II. Other significant conditions co	ntnbuting to death but not res	ulting in the	underlying cause	given in Part I.	23e. Did	tobacco use	contribute to	the cause of death?
ds,	uires n sign ild be	D D						_ 1	Yes 20	No 3□Pro	obably 4 DUnknown
00	2 0 5	ete						24a. Wa		24b. Were au	topsy findings available
Re	The lay	mo						per 1 Yes	opsy formed? 2 No	death?	completion of cause of
ita	sicien: Th certificete irector, pag	0	25. Was case referred to medical				26. Place of D	Death (Check only			
\	S 50	To B	examiner? 1 ☐ Yes ZXXVo	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatie	11. C 3011		g Home 5 ☐ Re	sidence 6 [Other (Spec	cify)
0	Dn 0 0	 	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time Injury	W		28d. Describe	how injury o	occurred	
Sio	tendin death. tor: Aft the fur	cati	2 Accident investigation 3 Suicide 6 Could not be	On Blace of Laine At h	40		□Yes 2□No	29f Location	/Street and	Number or Ri	ural Route Number,
Division of Vital Records,	or At after of Direct in by	Certification:	4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif	bme, iarm, s by)	теет, тастогу, опто	θ		own, State)	vamber of the	ar notio rumbor,
	To the Hospitel or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical Ce	(Check only 2 Medical Exami	rsician: To the best of my kno iner: On the basis of examina							
	thin 2 the control	Med	29b. Signature and title of certifier	and manner stated.		29c. Lice	nse number		29d. Date	signed (Monti	h, Dey, Year)
	8 48 4		1 Linne	12/10		D00	026024		08-	13-20	008
	(20)		30. Name and address of person who c	ompleted cause of death (Iter	n 23a) (Type						
12	-60)		Dr. Lester Mil				, N.E.	Washing	gton,	DC	20017
		ate	31. Date filed (Month, Day, Year)	32. Registrar's Signa	atue	,					
	Regist	rar	AUG 1 5 2008	Walnut Jo A	100						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State o	f Mar	yland / De	epartmer Certifica	it of ⊢ e of L	lealth a D <i>eath</i>	nd Me		giene Reg. No.	2008	27810
		1. Decedent's Name (First, Middle, Last,							2	2. Date of Dea Month	ith Day	Year	3. Time of Death
Physici /Medio		Anna Smi	th							Aug 7,	20°C	8	5:30A M
Examir		4a. Facility Name (If not institution, give		mber)		4b. City,	Town, or	Location of	Death			County of Death	
		6427 24th P1ac	е			1 -		ille	- 1			ince Ge	
Funeral Director		311 20 3070	(]M 2∏ F	7. Age 92	(In yrs. last birthe Yr	Months		If Under 24 Hours	Min. I	B. Date of Birt Month 7a	Y4291	9. Birth Wast	place (State or Foreign Mington DC
and w		Usual Residence of Decedent 10a. State 10b. County			Ioc. City, Town o	r Location	_				<u> </u>		10d. Inside City Limits
Maryla a-f sho	to	Maryland Prince G	eorge'		Hyattsv								1 □ Yes 2 XXIo
th with the 23a or 28	al Director	10e. Street and Number 6427 24th Place				10f. Zi	Code 20782	2				en of What Cou ited Sta	
s after dea	by Funeral	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Dec Armed Fo 1 ∐Yes If Yes, Gi	rces? 2 K] No ve	er in U.S.	13. Was Dece If Yes, spe 1 ☐ Yes		ispanic Origi in, Mexican, Specify:	in? (Speci Puerto Ri	ify Yes or No- can, etc.)	i i	4. Race - Amer Black, White Specify: Wh	etc.
perfullible; Intellible with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	Completed b	3 🖫 Widowed 4 □ Divorced 15. Decedent's Edu (Specify only highest grad	Year or D cation e completed) College ((f	ecedent's Usu Give kind of wo ife. DO NOT u	rk done o	durina most d	of working		16b. Kir	nd of Business/li	ndustry
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vid be file Mental Hy rrked oth	To Be	17. Father's Name (First, Middle, Last) William W. Piero	.e							First, Middle, ary Ze.			
und 2 sho alth and 1.27 is ma		19a. Informant's Name/Relationship (7) Mary Ann Ritenour		<u>.</u>)								Del 199	
or other		20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐ F	temoval from	State	20b. Place of D cemetery,	isposition (Na crematory or	me of other plac	Aug 1	3, 2	800		cation - City or T	
Deficiency Pages Department of mportant: If it any Injury or once.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens			Washin	gton N	ation	nal Ce	mete:	ry	Suit.	land, Ma	aryland 6633 Old
Department of the control of the con	6	21. Signatura of Funeral Sorvice kicens	7	0257		Alexan	dria	Ferry	Roa	d. Cli	nton	, MD 20	0735
		23a. Part 1. Enter the disease, or compl shock, or heart failure. List only o	ications that	caused th	ne death. Do no								Approximate Interval Between
Physician /Medical Examiner	8 5	Immediate Cause (Final disease or condition resulting in death)	CHR	אוכ	OBST		د ا	PULMO	NAR	y DI	A 32	32	Onset and Death
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rtificat ng phy as the	/ledi	ve eeuwe											
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. Within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		birth 2 nant at t	pregnancy Fetal death ime of death	3 Ectopic 5 Other (s		у			2	3d. Date of deli Month	very Day Year
w requires that been signed be deta	þ	Part II. Other significant conditions co	ntributing to d	eath but	not resulting in t	he underlying	ause giv	en in Part I.		23e. Did to			the cause of death?
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ding Physician: The law h. After this certificate has funeral director, page 2.	Completed	- Africa Company								autop perfo 1 □ Yes	rmed?	prior to death? 1 ☐ Yes	ompletion of cause of 2 No
viciar iciar certif	Be	25. Was case referred to medical examiner?	lospital:				Oth	26. Place	of Death (Check only o	ne)	3737	Assistied
Phys	은	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date		2 ER/Outp		JA	vat	sing Home	e 5 🗌 Resid 3d. Describe f	dence 6	Other (Spec	Assistied Living
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al or Atter	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place build	e of Injury ing, etc.	/ - At home, farm (Specify)	, street, factor	y, office		28	3f. Location (S City or Tov	Street and vn, State)	d Number or Ru)	ral Route Number,
re Hospita 124 hours re Funera	Medical C	29a. Certifier Certifying Phy (Check only one) 2 Medical Example		pasis of e	examination and/								
To th withir To th	Me	29b. Signature and title of certifier	10	12	10			e number				e signed (Month	
		Natural HX	Mars	/"	1D	T	00	5552	12		1-100	10st 8	, 2008

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ROBERT H GERARD 110 Inving St NW Rm GB-10 WASHINGTON DC 20010

31. Date filed (Month, Day, Year)

AUG 1 4 2008

AUG 1 4 2008 ROBERT H GERARD

31. Date filed (Month, Day, Year)

AUG 1 4 2008

Donnell Wayne Smith, Sr.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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			_	-		-	

		- For State	Certificate of Death Reg. No.											
Physicia		Decedent's Name (First, Middl	ent's Name (First, Middle,Last)							ay Ye	ear	3. Time of Death		
ત્રી Examir		DONNELL WAYNE	SMITH					Α̈́υ	August 6, 2008 0602 hrs					
		4a. Facility Name (if not institutio	n, give street and n	umber)	4	b. City, Town, or	Location of I	Death		4c. County				
***		Prince George's Hosp	ital Center			Cheverly					George			
Funeral		5. Social Security Number	mber 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs.								8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign			
Director	- 1	578 86 9496	Months Days Hours Min.							959	Co	ountry) D.C.		
			121 M 2 F	l	70 113.				1/10/1	,,,,				
20		Usual Residence of Decedent 10a, State 10b, County		10c. City.	Town or Locati	on						10d. Inside City Limits		
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Mary Mary	Director	10e. Street and Number				10f. Zip Code			ľ					
If the Maryland 13a or 28a-f sho		329 35TH STREE	T NE			20019			UN	IITED				
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2 ho	ompleted	Elementary/Secondary (0-12)	College	(1-4 or 5+)			. DO NOT u	se retired)				_		
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d wii	ड़ी	17. Father's Name (First, Middle	, Last)				18.Mother's	Name (Firs	t, Middle, Ma	iden Surnar	ne)			
21215-0036 Uld be filed within 7 Mental Hygiene. marked other that	Be (KIRTIS SMITH,	SR.						INE BA					
21; Men Men mari	<u></u>	19a. Informant's Name/Relations	ship (Type, Print)		19b. Mailin	g Address (Stree	et and Numb	er or Rural	Route Numb	er, City or T	own, Stat	e, Zip Code)		
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other that "matural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	$\lceil \rceil$	JOYCE A. SMITH	7	WIFE	329 3	5th ST.	NE WA	SHING	TON, D	.C. 20	3019			
and and lealth	ŀ	20a. Method of Disposition				ition (Name of ce	metery,	Da	te	20c. Locatio	n - City o	or Town, State		
more Pages 1 nent of H ant: If i		1 Burial 2 X Crematio	n · 3 Removal	from State	crematory or ot		->-	00/00	/2000	n r (7 m n)	DATE	MADVIAND		
Pag ment	L	4 Donation 5 Other S	pecify:	RI	VERDALE	PARK CR	EM.	U8/22	ן 2008 <u> </u> ודעם י	RIAFE	NER A	, MARYLAND		
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed with Department of Health and Mental Hygiene. Important: If item 27 is marked other thinjury or other traumatic event, the Med		21. Signature of Funeral Service	Licensee	(00d					N T. RHINES FUNERAL HOME, LLC ASHINGTON, D.C. 20017					
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hysician	1	failure. List only one cause	on each line.									Between Onset and Death		
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	- 1	or condition resulting in death)	Due to (or as	a consequence of	of):									
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760, ficate be g physical the buri	Jed Jed	IF FEMALE:	23c. If ve	s, outcome of pre	gnancy					23d. Date	e of delive	ery		
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Box 68 e death certif the attending ed for use as	Phys			known										
ords, P.O. Box 68 w requires that the death certif s been signed by the attending should be detached for use as		Part II. Other significant cond	tions contributing	g to death but not	resulting in the	underlying cause	given in Pa	rt I.				to the cause of death?		
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tal Recian: The certificate	Cor					00 File	(D 1)	(Observe and	1 Yes 2	No No	1 🗸	Tes 2 No		
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medic examiner?	Hospital:	1			Other			Residence	6 Ott	hori		
Division of Vital Records, tal or attending Physician: The law requirers after death. al Director: After this certificate has been side in by the funeral director, page 2 should be in by the funeral director, page 2 should be also be a should be also be a should be also be als	70	1 ✓ Yes 2 No	, L.	Inpatient 2 ₩				Nursing H	d. Describe h		-			
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ion tend cath. tor:	atio	J. Pe	nding estigation				Yes 2							
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Divis Spital or A hours after meral Dire	Certification:	4 Homicide	ermined (Speci											
D Hospital 24 hours Funeral tely filled	a	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated.								tated.				
Division of Vital Records, P.O. Box 68760, To the Hospital or Athending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical	one) 2 Medical Ex	aminer: On the bas and manne	is of examination er stated.	and/or investig	ation, in my opinic	on, death oc	curred at th	e time, date a	and place, a	na aue to	the cause(s)		
T W TO	Me	29b. Signature and title of certi		. /		29c. Licer	se number			29d. Date	signed (f	Month, Day, Year)		
		MI. A.	2011/	M		0.0	M.E.			August	7, 2008	3		
		30, Name and address of person	aske 4	ause of death (Ite	m 23a)									
		Melissa Brassell, ME		Medical Exam		Penn Street,	Baltimore	e, MD 21	201					
	tate			Registrar's Sign										
Regis		3 AUG 2 (M1" 2008 60	Blown	J. A	ser!									

DHMH 17 Rev 1/2001 OCME 2006

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	i	1- For State Certificate of I	Death	Re	_{g. No.} 20	00 670					
Physicia	an/	1. Decedent's Name (First, Middle,Last)		2. Date of Death Month	Day Year	3. Time of Death 1756 hrs					
si Exami		Henry Edward Tyler 4a. Facility Name (if not institution, give street and number) 4b	c. City, Town, or Location of D	August 9, 2	4c. County of De						
			Annapolis		Anne Arund	el					
Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	If Under 1 Year If Under 2 Months Days Hours	Min		Birthplace (State or Foreig Country) 【aryland					
A .	. [Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits					
Maryland 28a-f show any d at once.		Maryland Anne Arundel Annapolis									
tryland Sa-f sh at onc	턍	10e. Street and Number	10f. Zip Code	10	g. Citizen of What C	ountry?					
the Ma	Di e	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 21401 USA									
within 72 hours after death with the Maryland giene. her than "natural", or items 23a or 28a-f sho Medical Examiner must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Yes	Decedent of Hispanic Origina s, specify Cuban, Mexican, Po	? (Specify Yes or No- luerto Rican, etc.)	14. Race - An White, etc	nerican Indian, Black,					
fler de	핏	1 X Yes 2 No 3 X Widowed 4 Divorced If Yes, Give Year 1956-58 1	Yes 2 X No specify:		Specify:	Black					
natura xamir	d be	during mos	s Usual Occupation (Give kinds st of working life, DO NOT use		16b. Kind of Busine	ss/Industry					
permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner.	Sete	Elementary/Secondary (0-12) College (1-4 or 5+)			C-16 B-						
giene. her th	Completed	10th 0 Co	nstruction	Name (First, Middle, M	Self Er	nproyea					
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Meni Meni mari	5		Address (Street and Number	er or Rural Route Nun	ber, City or Town, S	tate, Zip Code)					
12 shoth and 127 is			ris Street		is, Md.	21401					
f Heal		20a. Method of Disposition 20b. Place of Disposit crematory or other	tion (Name of cemetery, er place)	Date	20c. Location - City	or Town, State					
Page nent o ant: or oth		4 Donation 5 Other Specify: Maryland		3-15-08		ville, Md.					
epartu nport njury	ı	21. Signature of Funeral Service Licensee 22 Mar	ime and Russis of Fability								
	0	23a. Part I. Inter the disease, or complications that caused the death. Do not enter the	21 West St.	_		Approximate Interv					
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Baltimore, Maryland 21215-0036

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show
any injury or other traumatic event, the Widon Extra Action 12 to 100 filed at 200 once.

Physic /Med Exam

Physician Medical Examiner

R	Division of Vital Records, P.O. Box 68760,	
Regi	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Examin
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	1 - State Registrar				C	Certifica	ate of	Death			Reg. N			61	J C
.:	1. Decedent's Name (First	, Middle, Last)								2. Date of De Month		ay	Year	3. Time of D	eath
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iner	4a. Facility Name (If not in WASHINGTON			*	•			r Location			4c. County of Death MONTGOMERY				
	5 Social Security Number 6 Sex 7 Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth								te of Birth 9. Birthplace (State or Fo				Foreign		
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ပို	17. Father's Name (First, I	Middle. Last)			<u> </u>			18. Moth	er's Name	(First, Middle	Maide	n Surnan	ne)		
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	20a. Method of Disposition			20b. F		isposition (A		CKLLIN		Date					
	1 ☐ Burial 2 ☐ Crem 4 ☐ Donation 5 ☐ O	nation 3 🗆 Re	moval from	State	cemetery,	crematory o LE CR	r other plac			/2008		: Location - City or Town, State VERDALE, MARYLAND			
	21. Signature of Funeral S	Service Licensee	a (1)		22. Name			· J.	B. JEN				L HOME 20785	
	23a. Part 1. Enter the dise shock, or heart failur	ase, r complica	ations that c	aused the deat	h. Do not	-								Approximate	
	Immediate Cause (Final	e. List only one	cause on e											Interval Betw Onset and De	een eath
•	disease or condition resulting in death)	a.	Due to (or as a conseq	UEDCE of	7046	Cey	dill	ascar	la di	ye	ex	-		
	R C C C														
je je	Sequentially list conditions	b.	Due to (ui as a vuiiscy	uence of):	-		0	5.4						
Examiner	Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	1 6.	1	Acute Venal failure											
	resulting in death) Last		Due to (or as a conseq	uence of):										
Medical		d.		-											
ĕ.	IF FEMALE:														
	23b. Was decedent pregning in the past 12 months	ant	1 🗌 Live b	come of pregna pirth 2 ☐ Feta	l death	3 🗆 Ectopia		;y			23d. Date of delivery Month Day Year			a ar	
by Physician	1 □Yes 2 □No 9 □ Unknown		4 ☐ Pregr 9 ☐ Unkn	nant at time of o own	death	5 Other	(specify) _					1910	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	24)	,
P /	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use 1 Yes 2 No. 24a. Was an autopsy performed? 1 Yes 2 No.								use cont	use contribute to the cause of death?					
Q D									2 □ No	3 ☐ Prob	bably 4 🗆 Ui	nknown			
lete									an	24b	Were auto	ppsy findings a	vailable		
Completed										prior to co death?	mpletion of ca	use of			
3e C	25. Was case referred to medical examiner?									2 22110	_				
										fy)					
27. Manner Ceath 1 atural 5 Pending 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Work? 28c. Injury at Work? 28d. Describe how injury occurred Work?								red							
atic	2 Accident	investigation				M		Yes 2□	No						
1 Yes 2 Ne									28f. Location (Street and Number or Rural Route Number, City or Town, State)						
ical C	(Check only 2 M	ertifying Physic edical Examine	er: On the ba	asis of examina	wiedge, d	leath occurre	ed at the ti	me, date a	ind place, ath occurr	and due to the	cause date a	(s) and m	anner as s	stated.	
Med	one) 29b. Signature and title of		and manr	ner stated.			9c. Licens							Day, Year)	
	Thu	4			1)				0 0			-t (-		oug, rear)	
	20 Name and address of	INA 12	noloted as:	tmess (than	020\/7:	no Bei-A)	TA11	000	Ain	1			0		
	30. Name and address of p	ws i'm	BLV	D E	(L , !	pe, Print)	Sho	MY A	40 2	0903.	m Z	O P			
ate	31. Date filed (Month, Day,	Year)	32. R	egistrar's Signa	ture	3,									
rar	AUG 1 5 2	UUO A	العرف	D A	-										

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician August 12, 2008 3:23 a Shirley Edwards Van Sant /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Suburban Hospital Bethesda 8. Date of Birth (Month, Day, Year June 10, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Hours Months Days Min. 1 □ M 2 K F Yrs 1921 Connecticut 87 044-12-6559 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 Is marked other than "natural", or items 23a or 28e-4-1 any injury or other traumatic event, the Marked one. 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County 1 TYes 2 KINo Director Kensington Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20895 USA 4304 Colchester Drive by Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black. White, etc. 1 ∐Yes 2**xTx**No IfYes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 → No White Specify Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own_Home 12 Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Gladys Foster Harry Edwards ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 4304 Colchester Drive, Kensington, MD 20895 Delmar Van Sant/Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition Aug. 12, 1 ☐ Burial 2 ☐xCremation 3 ☐ Removal from State Metropolitan Crematory 4 ☐ Donation 5 ☐ Other (Specify) 2008 Alexandria, Virginia 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. 21. Signature of Funeral Service Licensee Cusa M 500 University Blvd., W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications trait aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Pulmonary Fibrosis 4 vears /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin, Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical attending p for use as t 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 X Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe this certificate 1 ☐Yes 2 ☐ No 2 🕃 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 □ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

8/13/2008 or Attending Physician: within 24 hours are. ____ To the Funeral Director. A Hospital

> State Registrar

Medical

29a. Certifier

31. Date filed (Month, Day, Year)

AUG

13

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD Michael A. Westerman,

2008

and manner stated

P.o. Box 2316, Kensington, MD 20891-2316

🛮 🕱 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

August 12, 2008

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Nancy Fields Wilcox 2008 9:45 August. 11. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery General Hospital Olney Montgomery If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕱 F Yrs. Oct. 14, 1916 Virginia 91 Director 214-46-6606 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mential Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 21 No Directo Montgomery Olney Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20832 USA 17540 Queen Elizabeth Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 □Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: White ò 3 Midowed 4 ☐ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edith Rebecca MacFarland Joseph Thomas Harris ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Fred T. Wilcox/Son 17540 Queen Elizabeth Drive, Olney, MD 20832 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Aug. 15 2<u>008</u> 15, 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Burtonsville Union Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Burtonsville, Maryland 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. suum all an 500 University Blvd, W., Silver Spring, MD 20901 Approximate Interval Between Onset and Death 23a. Part 1. Enter the dilease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart fillure. List only one cause on each line. Immediate Cause (Final **Physician** /Medical resulting in death) Dut to (or as e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) the death certificate be executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician d be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown The law requires that 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check onl one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Certification: To this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide

completely filled in by the funeral after death Director: Hospital or To the Hospital within 24 hours a To the Funeral C

State

cal

29a. Certifier

29b. Signature and title of certifier

nhanbo

Registrar

DHMH 17 Rev 1/2001

and manner stated.

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

DI

State of Maryland / Department of Health and Mental Hygiene

AUG 1 5 2008

For State Registre Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AUGUST 2008 TÖ 2:22 P WRIGHT ROBERT Τ., /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S FT. WASHINGTON FORT WASHINGTON HOSPITAL If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year) MAY 5 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Months SOUTH CAROLINA 578-50-3888 78 Yrs Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ∑Yes 2 ☐ No 10f. Zip Code 10g. Citizen of What Country? USA 20745 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. BLACK 1 Tes 2 No Specify 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Give kind of work done during most of working life. DO NOT use retired) GOVERNMENT ENGINEER 18. Mother's Name (First, Middle, Maiden Surname) MATTIE MAE REVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8103 HAMPTON VILLAGE WAY BRANDYWINE, MARYLAND 20613 20b. Place of Disposition (Name of cometery, crematory or other place) Date 20c. Location - City or Town, State MARYLAND VETERANS CEME 8/22/2008 CHELTENHAM, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME /474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MUDONAM RAS un known 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ☑ No 24a. Was an 1 Yes 2 No 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3□ DOA 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Describing Physician: To the bast of my knowledge death occurred at the tinis, date and place, and due to the cause(s) and interior be stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifie Medical (Check only one) 29b. Signature and title of sertifier 29c. License number 29d. Date signed (Month, Day, Year) MA elus 7005P5PS 30. Name and address of per on who completed cause of death (Item 23a) (Type, Print) SAMUEL J. KLEIMAN M.D. 11701 LIVINGSTON RD FORT WASHINGTON, MARYLAND 20744 32. Registrar's Signat 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

completely

Funeral

Director

08-06144 Hilda Woods Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hydiene

la Woods	1-	State of Maryland / Department of Health and Meritar From State Certificate of Death	Reg. I					
Physicia	n/ Re	gistrar Decedent's Name (First, Middle,Last)	Date of Death Month Da August 12, 2	3. Time of Death				
dical Examir	er	HILDA WOODS a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	August 12, 2	4c. County of Death				
	4	Spring Grove Hospital Center Catonsville	3	Baltimore County				
Funeral Director	5	Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. Months Days Hours Min.		MM/DD/YYYY 9. Birthplace (State or Foreign Country MARY LAND				
*	-	Usual Residence of Decedent Oa. State 10b. County 10c. City, Town or Location		10d. Inside City Limits				
d how any		MARYLAND PRINCE GEORGES TEMPLE HILLS		1 Yes 2 XNo				
farylan 28a-f s	Director	0e. Street and Number 10f. Zip Code	"	10g. Citizen of What Country? UNITED STATES				
h the A		5307 CHESTERFIELD DRIVE 20748 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (St	pecify Yes or No-	14. Race - American Indian, Black,				
death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	White, etc.				
	by Fu	3 Widowed 4 X Divorced of Dates:	work done	Specify: BLACK 6b. Kind of Business/Industry				
hours a		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret						
36 hin 72 e. than "	Completed	12TH GRADE HOUSEWIFE	- 1	HOMEMAKING				
D 21215-0036 should be filed within 72 hours after death with the Maryland and Montal Hygiener, 17 is market other than "natural", or items 23a or 28a-f she 7 is market other than "natural", or items 23a or 28a-f she natic eveut, the Medical Examiner must be notified at once		17 Father's Name (First, Middle, Last)	e (First, Middle, Ma					
2121 Jild be f Mental marked: event	o Be	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or	Rural Route Numb	per, City or Town, State, Zip Code) 20748				
MD 12 show th and 127 is umatic		ERNEST D. FOWLER / SON 5307 CHESTERFIELD DRI	VE TEMP	LE HTLLS MARYLAND 20c. Location - City or Town, State				
imore, MD 21215-0036 Pages I and 2 should be filed within 72 hours after ment of Fell and and Mendal Hygiene, man free than "matural", and fitten 27 is marked other than "natural", or other traumatic event, the Medical Examiner.	1	Zyo. Method of Stoppedian 3 Removal from State crematory or other place)						
Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumat		4 Donation 5 Other Specify: 21. Ignature of Fu., al Se, i.e. iceas: 4 Donation 5 Other Specify: 22. Name and Address of Facility THO						
Bal permi Depa Impo injur		TVITER C TUNIDATION TOURSON MOOSES 1 3439 LIVINGSTON R	COAD. IND.	LAN HEAD.MARYLAND				
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arre	Between Onset and Death				
Medical/ Medical		Immediate Cause (Final disease or condition resulting in death) a. Hypertensive Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):						
		Sequentially list conditions, b						
	nine	The course of th						
cuted and transit	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):						
al an	ledical	UNPENDED AMENDED						
	/Med	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic preg	gnancy	23d. Date of delivery Month Day Year				
Box 68766 E death certificate the attending played for use as the b	sician/M	past 12 months? 4 Pregnant at time of death 5 Other (Specify)						
BO) te death the att	2	1 Yes 2 V No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	bacco use contribute to the cause of death?				
F. P.O. ires that the signed by		Diabetes mellitus	1 Yes	s 2 No 3 Probably 4 Unknown				
cords, law require has been si	Completed by		24a. Was autor	prior to completion of cause of				
ecol he law ate has	d mc		1 🗸 Yes	The state of the s				
tal Rec ician: The l certificate l	Be C	25. Was case referred to medical examiner? 26.Place of Death (Che examiner? Hospital: ,	rsing Home 5	Residence 6 Other:				
f Vit Physic	2	1 Ves 2 No Inpatient 2 Envougation 3 28c. Injury at Work?		how injury occurred				
ion of \text{ tending Phy eath.} to: After the funeral of the fun	ion:	1 Natural 5 Pending (Month, Day, Year)						
Division of Vital Records, tal or Attending Physician: The law requirers after death. After this certificate has been study in burst or a short care in burst of the study of	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (or Town,	Street and Number or Rural Route Number, City State)				
Divisior To the Hospital or Attend within 24 hours after death To the Funeral Director:			and due to the cau	se(s) and manner as stated.				
To the Hospital within 24 hours	Medical	29a. Certifying Physician: To the best of my knowledge, death occurred at the lifte, date and place, (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	ed at the time, date	s and place, and due to the best (1)				
5 ½ £	Me			29d. Date signed (Month, Day, Year) August 12, 2008				
		O.C.M.E.		7.09401.12, 2000				
SRZ	1	30. Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore	, MD 21201					
(1)DJ	State	32 Project at 4 of Services 32 Project ar's Signature						
	ietra	HUBIT # COOO KARKAN SO KARAKU						

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	1	For State of Maryland / Department of State of Maryland / Department / Dep	rtificate of Death	Reg.	0000 0 0 0 10							
Physicia /Medic	an	Decedent's Name (First, Middle, Last) THOMAS EDWIN WALLS		2. Date of Death Month UGUST 1	2 2008 3. Time of Death 10:00 A M							
Examin		4a. Facility Name (If not institution, give street and number) 805 CLABBER HILL ROAD	4b. City, Town, or Location of Death CHURCH HILL		4c. County of Death QUEEN ANNE							
Funeral Director		5. Social Security Number 216-18-2212 6. Sex 1	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	B. Date of Birth (Month, Day, You JULY 20,	9. Birthplace (State or Foreign Country) MARYLAND							
Maryland a-f show	ctor	Usual Residence of Decedent 10b. County 10c. City, Town or Low MD QUEEN ANNE CHURCH	HILL		10d. Inside City Limits 1 □ Yes 2 No							
n with the	al Director	10e. Street and Number 805 CLABBER HILL ROAD	10f. Zip Code 21623	10g	. Citizen of What Country?							
LIZISTONOSO Jwithin 72 hours after death with the Maryland jane. Than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by Funeral	11. Marital Status 1 Never Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Specifyes, specify Cuban, Mexican, Puerto F	cify Yes or No- lican, etc.)	14. Race - American Indian, Black, White, etc. Specify: WHITE							
within 72 hours af tiene. "natural", or the Medical Exami	Completed	(Specify only highest grade completed) [Given: [Given: Appleted] (Given: Given: edent's Usual Occupation e kind of work done during most of workin DO NOT use retired) MER	g 16	b. Kind of Business/Industry FARMING								
be filed tal Hyg d othe event,	To Be Co	9 –U– FAR 17. Father's Name (First, Middle, Last) JAMES HARRY WALLS	18. Mother's Name	(First, Middle, Ma								
re, Marylario s 1 and 2 should be file Health and Mental H tem 27 is marked oth other traumatic even		MRS. BETTY WALLS/ WIFE 805	ing Address (Street and Number or Rural CLABBER HILL ROAD,	CHURCH	HILL, MD 21623							
0 00 = =		1 Burial 2 □ Cremation 3 □ Removal from State WOODLAWN	MEMORIAL PARK 8–1	5-2008	EASTON, MD							
Defiling Defiling Defiling Defiling Defiling Page Defiling Page Defiling Page Defiling	er	21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P 408 S. LIBERTY ST., CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):										
cords, P.O. Box 68/60, w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	in/Medical Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last C	:□Ectopic pregnancy	23d. Date of delivery Month Day Year								
y, P.O. BOX that the death cer hed by the attendin detached for use	y Physician/M		□ Other (specify)underlying cause given in Part I.		acco use contribute to the cause of death?							
or Vital Records, P.O. BOX to Physician: The law requires that the death certificate has been signed by the attending rathic dector, page 2 should be detached for use and	Completed by	Coronary Artery Discose Partingons Discose	the fer lenslo.	24a. Was an autopsy perform	24b. Were autopsy findings available prior to completion of cause of							
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Division or Vital Records, To the Hospital or Attending Physician: The law requires t within 24 hours after death. Yo the Funeral Director: After this certificate has been signe completely filled in by the funeral director, page 2 should be o	Certification:	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, shuiding, etc. (Specify)	M 1 ☐ Yes 2 ☐ No	28f. Location (Str City or Town	Describe how injury occurred Location (Street and Number or Rural Route Number, City or Town, State)							
ne Hospita ne Hospita ne Funeral	Medical C	29a. Certifiler (Check only one) Certifying Physician: To the best of my knowledge, de 2 Medical Examiner: On the basis of examination and/or and manner stated.	ath occurred at the time, date and place, investigation, in my opinion, death occur	red at the time, da	ate and place, and due to the cause(s)							
To the within the comp	Me	29b. Signature and title of coaffier	29c. License number		August 14, 200 8							
40		30. Name and address of person who completed cause of death (Item 23a) (Type 1	pe, Print) 55 (yn ward I	Sr. E	August 14, 2008							
S Regis	tate trar	AUG 1 4 2008 32. Fegistrar's Signature	goods .									

		1. Decedent's Name (First, Middle, Last) Louis Ancrum		2. Date of Deat	_) 08 °	3. Time of Deat 2: 30 a
ysicia Medic	al .		Location of Death	00	4c. County		2: 30 a
camino	51	Prince George's Hospital Cheverly			Prince	Geo	
neral ector		5. Social Security Number 254-92-1170 C. Sex 1. Security Number 5. Sex 1. Security Number 5. Sex 1. Security Number 5. Sex 1. Security Number 1.	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 02–18–1	Year)		lace (State or For try) Carolin
	_ H	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location					Od. Inside City Lin
fled at	.	Maryland Prince George's Bladensburg					1 ☐Yes 2□
st be noti	Direc	10e. Street and Number 3801 Kenilworth Avenue 10f. Zip Code 20710)	10	0g. Citizen of W	Vhat Coun	try?
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t, the N	E COM	12yrs. +2yrs.					ounty Sh
tic even	To Be	17. Father's Name (First, Middle, Last) Val Ancrum	18. Mother's Name Theresa		vialden Surnam	10)	
traum	-	19a. Informant's Name/Relationship (Type. Print) Calvin Ancrum/ Nephew 19b. Mailing Address (Street at 4730 6th Place)			-		Code)
any injury or other		20a. Method of Disposition 1 Description 20b. Place of Disposition (Name of cemetery, crematory or other place of Disposition (Name of Cemetery, Crematory) or other place of Disposition (Name of Cemetery, Crematory) or other place of Disposition (Name of Cemetery)	ge) 9 09-04		20c. Location - Arlingto		own, State Tirginia
any injur once.		21. Signature of Funeral Service Licensee 22. Name and Address 3005 12th					
	= ==	23a. Part I Inter the disease, or complications that caused the Math. Do not enter the mode of dyin shork, or heart failure. List only one cause on each line.	ng, such as cardiac	or respiratory arr	est,		Approximate Interval Between
		Immediate Cause (Final	1 - 10				Onset and Deat
cian dical niner	Examiner	Immedial Cause (Final disease or condition resulting in death) Sequentially list conditions, if airy, leading to finingulate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):	oleedi	ng		AMINERY	Onset and Death
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Reg. No. 20 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month **Physician** Year /Medical 4a. Facility Name (If not institution, give street and humber) Examiner 4b. City. Town, or Location of Death 4c. County of Death 5. Social Security If Under 24 Hrs. 8. Date of Birth (Month, Day, 9 Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Year) 1□M 2 1 F Months Days Hours Min. **Director** Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural" or items 23a or 28a-f show any linury or other traumatic event, the Medical Exercises that the present once. 10a, State 10b. County 10c City Town or Location 10d. Inside City Limits Director 1 Yes 2 No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No ģ Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Ye 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ပ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or all Route Number, City or Town, State, Zip Code) odn. # 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 2008 4 Donation 5 Dother (Specify) emeter 21. Signature of Funeral Service Licenses 22. Name and Address of Pacility W. North Ave Bulto. 23a. Part I. Enter the direct ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sh. of heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Gliobastoma multitorme months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) burial-tran The law requires that the death certificate be exec Due to (or as a consequence of): attending physician for use as the buria P.O. Box 68760 yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ned by the atter detached for u 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 ☐ Pregnant at time of death
9 ☐ Unknown 5 Other (specify) 9 Unknow this certificate has been signed by al director, page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performe 1 ☐ Yes 1 ☐ Yes To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director: After this certification properties in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospice 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 1 □Yes 2 □No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier Ertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the Ho within 24 h To the Ful and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 1788 (MO -25-08

Registrar

State

AUG 2 2008

31. Date filed (Month, Day, Year)



30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Polk

MO



Bel

Air, MD

08-Wil

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	4	a. Facility Name (if not institution		umber)		4b. City, To		ocation of	Death			inty of Dea more Co		
	Н	Saint Joseph Medical Center												
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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	의	19a. Informant's Name/Relation Francis X. Ba		rothor)						Fallst			1047	
MD ad 2 sho alth and m 27 is aumati	-	20a. Method of Disposition	aldwin (b	20b.	Place of Disp					Date	20c. Loc	ation - City	or Town, State	
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Baltimore, MD 2's permit. Pages I and 2 should Department of Health and M. Important: If item 2'1's mainjury or other traumatic e		21. Signature of Funeral Service		. 10 0		. Name and			Sc				Home, Inc.	
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	Σ	29b. Signature and title of cert	1.	. 0		'		.M.E.				ıst 25, 2	•	
		No me	Did 11				0.0		_					
-		30. Name and address of pers	son who completed	cause of death (Ite	em 23a)	111 Door	Stroot	t Baltin	nore N	/D 21201				

State Registrar

31. Date filed (Month, Day, Year)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 25 at por Maryland & Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 1.3 Month **Physician** 2008 4:35 a ^M August Rudolph W. Baer /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) DEC 23 1910 Months Days Hours 1**X**M 2□F 97 071-09-2332 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 □Yes 2X No Anne Arundel Gambrills Director MD 10g. Citizen of What Country? 10f, Zip Code 10e. Street and Number 21054 USA 1500 Branchwood Drive Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No If Yes, Give Year or Dates: 1941–45 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify 2 White 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Proprietor Retail 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Bertha W. Nagel Baer ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1500 Branchwood Drive, Gambrills, MD Marcie Baer - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 Normation 3 ☐ Removal from State Metro Crematory, Inc. 8/15/2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Sesice Licensee H. Williams ²²Cremation Society of Maryland, Inc. 4 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Hemat oma day disease or condition resulting in death) Due to (or as a consequence of): APROVED BY MEDICAL EXAMINER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of) CERTIF Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 tructive Pulmonary Disease 2X No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 25. Was case referred to medical 26. Place of Death (Check only one) To Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury
(Month, Day Year)

08/07/08

About AM 28b. Time of 5 , 20 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Fellusing walker 1 Arvatural 24 Accident 5 Pending 1 ☐ Yes investigation 3 ☐ Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) , 5 m 6 r 1 1 5 , m 0 4 Homicide 15 00 Branchwood Dr Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

The law requires that the death certificate be executed burial-tran $\mathcal{H}\mathcal{I}/\mathcal{I} \mathcal{P} \mathcal{S} \mathcal{L}$ Division or Vital Records, P.O. Box 68760, attending p for use as 1 ed by the a detached f cate has been signed page 2 should be dei certificate this funeral After after death Director: filled in by the within 24 hours a completely

Funeral

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28a-f sh notified

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death

Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural"; or Ite

permit. Page Department o Important: If any injury or

Physician

/Medical

Examiner

item 27 is marked other than "natu other traumatic event, the Medical

Baltimore, Maryland 21215-0036

State Registrar one)

29b. Signature and title of certifie

29d. Date signed (Month, Day, Year)

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Defense Hwy, Crofton, MD 21114 225 a Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

State

Registrar

AUG 2 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) egentres. Lorin Willguard 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ANNE AMENDE Actuate - CUBIADAG on heed. On. Flew If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) cial Security Number (In yrs. last birthday) Months 1 X M 2 □ F Sept 26, 1918 484-01-2526 89 Iowa Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 Yes 2 □ No Maryland Anne Arundel Odenton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 558 Rita Drive 21113 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 X Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 🙀 Married 1 ☐ Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) United States Army 12 Staff Sergeant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mickkel Bakke <u>Christena</u> Nelson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 558 Rita Drive Odenton, Maryland 21113 ce of Disposition (Name of Date 20c. Location - City o Lilli Wilhelmine Bakke/wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State West Arundel Crematory 8/27/2008 Odenton, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signa are of Funeral Service Licen 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. Odenton, Maryland 21113 1411 Annapolis Road 23a. Part the first the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, reading to infine data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last IF FEMALE: 23c. If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 4 Pregnant at time of death 9 Unknown Month Dav Year in the past 12 months? 5 ☐ Other (specify) 1 Yes 2 No 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ NO 24a. Was an autopsy 1☐ Yes 2 No 25. Was case referred to medical examiner? 1 ☐ Yes 2 No 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient

certificate be executed and physician the as attending I Ö the signed by t d be detach يم Records, peen page 2 s has certificate or Vital After this funeral Division or Attending death.

Examiner Physician/Medical þ Completed Be ၉ Certification: within 24 hours after death

To the Funeral Director:
completely filled in by the Medical

Physician

/Medical

Examiner

Director

Funeral

Completed by

Be ဥ

Funeral

Director

other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at

. 1 and 2 should be filed within 72 hours after i Health and Mental Hygiene. tem 27 is marked other than "natural", or iten other traumatic event, <u>the Medical Exam</u>iner

important: if it any Injury or o once.

Physician

/Medical Examiner

Baltimore, Maryland 21215-0036

death with the Maryland

Hospital

State Registrar

5 Pending investigation

6 ☐ Could not be

determined

27. Manner of Death

1 Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

28a Date of Injury

and manner stated.

(Month, Day Year)

29c. License number

1 Yes 2 No

Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d, Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

AMERON

28d. Describe how injury occurred

30. Name and address of person who completed cause of death (Item 23a) (Type, Pripe 21061 32. Registrar

28b. Time of

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Certificate of Death

4b. City, Town, or Location of Death

Riderwood Retirement Community Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 06/29/1921 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F 87 098-16-9512 Director Usual Residence of Decedent 10b. County 10c. City. Town or Location 10a. State 28a-f show 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Experiment must be notified at Director Silver Spring Montgomery 10f. Zip Code 10e Street and Number 20904-3114 Gracefield Road #WC -218 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ⊠Yes 2 □ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No 2 3 ☐ Widowed 4 ☐ Divorced WWIL Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "ne amy injury or other traumatic event, thu Mental once. Elementary/Secondary (0-12) College (1-4or 5+) Electronics Engineer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Arthur Lee Burwell Bernerdine ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Sta 19a. Informant's Name/Relationship (Type. Print) 3114 Gracefield rd, #WC-218 Florence Emma Burwell/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Aug 29 20a. Method of Disposition 1 ☐ Burial 2 SCremation 3 ☐ Removal from State 2008 esapeake Crematas 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Rapp Funeral & Cremation Services 21. Signature of Funeral Service Licenses 933 Gist Ave. Silver Spring, Maryla 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Iliopsoas Abscess **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Diverticulitis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ending physician and use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy 5 Other (specify) □Yes 2□No 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, ₹ Hypertension, Coronary Artery Disease, Completed certificate or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specity) 1 Yes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To after all Director: After all Director: After all of the funeral of 28a. Date of Injury (Month, Day, Year) 28h. Time of 28c. Injury at Work? 27. Manner of Death Division 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident

State of Maryland / Department of Health and Mental Hygiene

2. Date of Death

ital Hy	giene		07205
	Reg. No. 2	108	27825
Date of De	eath		3. Time of Death
Month Augu:	st 27, 2	Year 008	4:00 PM _M
	4c. County		
ring		gome:	кA
Date of Bir (Month, D 06/	rth av, Year) 29/1921	9. Birthp Coun NY	lace (State or Foreign try)
		14	Od Incido City Limita
		10	Od. Inside City Limits
			1 ☐ Yes 2 🙀 No
	10g. Citizen of V	What Coun	try?
İ	USA		
Yes or No an, etc.)	o- 14. Rac Blac	e - Americ ck, White, e	an Indian, etc.
	Specify	/: B1a	ack
	16b. Kind of Bu	usiness/Inc	dustry
	Dept	of	NEVY
rst, Middle	, Maiden Surnan	ne)	
е На	rris		
oute Numb VC - 2	per, City or Town,	State, Zip	code)
.~ 20	20c. Location -		wn, State
ug 29 008	Belts	/ille,	Maryland
	Services .ng, Mary	land :	20910-
spiratory a	arrest,		Approximate Interval Between Onset and Death Months
		1	Months
		ite of delive	ery Day Year

23d Date of Month

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an

autopsy performed? 2 No -1 ☐ Yes

24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No

investigation 6 ☐ Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 28f. Location (Street and Number or Rural Route Number, City or Town, State)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Description: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29b. Signature and title of certifie.

3 🗌 Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

1. Decedent's Name (First, Middle, Last)

Francis Xavier Burwell

4a. Facility Name (If not institution, give street and number)

Physician

/Medical

Examiner

29c. License number

29d. Date signed (Month, Day, Year)

D24035

8/28/2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3110 Gracefield rd. Silver Spring, MD 20904 Eugenio Machado,

State Registrar

filled in by

Medical

within 24 hours a

To the Funeral D

completely filled i Hospital

> 31. Date filed (Month, Day, Year) 2008 AUG 29



Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** George Arthur Boston Jr. 26 2008 8:05a. /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Keswick Nursing Home 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ₹ M 2 □ F Months Days Hours Min. Yrs. Director 216-16-3980 82 MD 03 25 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ury or other traumatic event, the Modical Evanding 1, sist be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 Jestor Court 21207 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? X∏Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 □Yes 2 No Specify: Completed by Specify: 3 Widowed 4 Divorced Black 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Police Sergeant Police Department 4yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Rosie Mitchell George A. Boston Sr. 19a. Informant's Name/Relationship (Type. Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ethel Boston-Wife Jestor Court, Baltimore, Md 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of Important: If it any Injury or o once. Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arbutus Memorial Park 9/2/08 Arbutus, Md 22. Name and Address of Facility March F/H West Signature of Funeral Service Licensee 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner 030051 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): Dernen evere attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical au sea IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes funeral director, 25. Was case referre o medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Yes /2 No Other: 4 Nursing Home 5 | Residence 6 | Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 27. Manny of Death 28a. Date of Injury (Month, Day, Year) After t 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No

requires that the death certificate be executed Box 68760, P.0. Division of Vital Records, the Hospital or Attending Physician:

altimore, Maryland 21215-0036

within 24 hours after deam.

To the Funeral Director: Af 0+1

State Registrar

Medical

SHARMA VIJAY 31. Date filed (Month, Day, Year) AUG 2 9

29b. Signature and fule of certifier

3 ☐ Suicide

29a. Certifier (Check only one)

4 Homicide

2008

6 ☐ Could not be

determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

00064788

AUE

BALTINORE

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d, Date signed (Month, Dav. Year) 28 Ó

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1600 W. MT.

Registrar's Signature

ROTAL

■ Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		For State Registrar	Pleas			land / De	ера		. Ensure A lealth and N	Mental Hy		9	27827
Physicia		1. Decedent's Nam	, ,	Last)		BIT		· .		2. Date of De AUGUST		^y 2008	3. Time of Death 5:50 P M
/Medic Examine	er	4a. Facility Name ((If not institution, CHELWOOD Number	-		yrs. last birtho	day)_	4b. City, Town, o	r Location of Death IMORE If Under 24 Hrs. Hours Min.	L	1	County of Death	
Director show	_	Usual Residence of 10a. State	of Decedent 10b. County			. City, Town o	or Loc		<u> </u>	01/24/	/ 193/		10d. Inside City Limits 1 ☐ Yes 2 🖺 No
after death with the Marylan or items 23a or 28a-f show niver mast be rofffled at	al Director	MD 10e. Street and Nu 6703 (BALTIM Umber CHELWOOD			BALTIN	YOR	10f. Zip Code	.209		10g. Cit	tizen of What Cou USA	
al",	by Funeral	11. Marital Status	ried 2 🕅 Marrie	12 Was Dec	cedent Ever if orces? 2 \(\) No live Dates:	in U.S.			dispanic Origin? (Span, Mexican, Puerto	pecify Yes or No Rican, etc.)	0-	14. Race - Ameri Black, White,	
within 72 ho ene. than "natu	Completed	(Spe		grade completed) (1-4or 5+)	1 (0	Give k	ent's Usual Occup ind of work done O NOT use retired PRINTE	during most of worl d)	king	16b. K	ind of Business/Ir	
e d fall	To Be Co	17. Father's Name		<u> </u>		BITN	MAN		18. Mother's Nam	e (First, Middle	, Maiden	Surname)	NOWN
and 2 sho lealth and im 27 is ma her trauma			BITMAN /	,	l a	67	703	CHELWOO	and Number or Ru	BALTIMO	RE, I	MD 2120	9
oit. Pages 1 artment of F ortant; If ite njury or ot		4 ☐ Donation	•	1		cemetery,	S I N	AI CONG. Name and Addre	08/2	Date 8/2008	OW.	ocation - City or TINGS MIL 8 BROS.	LS, MD
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Physician /Medical		shock, or he Immediate Cause disease or conditi resulting in death)	(Final on	_a		nsequence of)	dal	the pa	inerest	2 4	ene	A .	Interval Between Onset and Death
be	al Examiner	Sequentially list or cause. Enter Und Cause (Disease o that initiated event resulting in death)	5	c		nsequence of)						7	
eath certificate attending phys for use as the	Physician/Medica	IF FEMALE: 23b. Was deceder in the past 12 1 □ Yes 2 9 □ Unknown	2 months? □No		birth 2 🗍 gnant at time	Fetal death		Ectopic pregnand Other (specify)	ру			23d. Date of delin	very Day Year
res the	2	Part II. Other sign	ificant condition	ns contributing to	death but not	t resulting in th	he un	derlying cause giv	ven in Part I.			din	the cause of death?
The law ate has b	Completed	25. Was case refe	arred to medical								opsy ormed? 2 X No	prior to c	opsy findings available ompletion of cause of 2 ⊟No
ding Physician: h. After this certific funeral director,	: To Be	examiner? 1 Yes 2 2	Ú No		Inpatient of Injury	2 ER/Outp		3 DOA Oth	4 🗆 Nursing H	14	idence	6 ☐ Other (Spec	ify)
To the Hospital or Attending Physician: within 24 hours after dea h. To the Funeral Director After this certific completely filled in by the funeral director,	Certification: To	1 Matural 2 □ Accident 3 □ Suicide 4 □ Homicide	5 ☐ Pending investiga 6 ☐ Could no determin	ation (Mo	nth, Day, Yea	At home, farm		Wor	kí?¨ Yes 2 □ No		(Street a	nd Number or Ru	ral Route Number,
To the Hospital or Atternwithin 24 hours after deal To the Funeral Director completely filled in by the	edical C	29a. Certifier (Check only one)	1	xaminer: On the	ne best of my basis of exa nner stated.	/ knowledge, omination and/	death or inv	occurred at the ti estigation, in my o	me, date and place opinion, death occu	, and due to the rred at the time	e cause(s	s) and manner as nd place, and due	stated. to the cause(s)
To the within comp	Ž	29b. Signature and	d title of certifier	el St	ess a	lypici	dr	29c. Licens	se number		29d. Da	ate signed (Month	, Day, Year)
3		30. Name and add	IL PUI	Tell J	HOVE	(Mem 23a) (Ty	ype, P 70	Print) & STEA	~ Ave	BALTIM	WP2,	mer	1224
Stat Registra		31. Date filed (Mo	AUG 2 9	2008	egistrar's S	signature	Lo	refer					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. #5, perFH G 883 9/16/08 TT State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 2008 8:05 P M Annette Andrea Contardi August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 913 Autumn Valley Lane Gambrills Anne Arundel If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 171-30-4344 Months Days Hours Min 1 □ M 2 🗓 F Yrs 69 11-13-1938 Pennsylvania Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heath and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f show ant: If item 27 is marked other than "natural", or intems 23a or 28a-f show any or other traumatic event, he Medical Examinar marke notified at any or other traumatic event, he Medical Examinar marke notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 🗓 No MD Gambrills Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21054 United States 913 Autumn Valley Lane 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 X Married Saltimore. Maryland 21215-0036 1 ☐Yes 2X No Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) National Elementary/Secondary (0-12) College (1-4or 5+) 3 Analyst Security Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ Michael Ciongoli Anna Arendous 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health as
Important: If item 27 is
any injury or other trau Kenneth R. Contardi / Husband 913 Autumn Valley Lane Gambrills, Maryland 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) Arundel Crematory 08-29-2008 Odenton, Maryland 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 21. Signature of Funeral Service Licensee M01522 Han 1. Enter the disease, or conshock, or heart failure. List only Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of. Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): Box 68760. physician Physician/Medical the attending IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 XNo Month Day Year 5 ☐ Other (specify) P.O. 9 HInknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records. ð 1 ☐ Yes 2 ☐ No Probably 4 ☐ Unknown Completed Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas After this certificate death? 1 □ Yes Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home Hospital: 1 Yes 2 No Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To Date of Injury (Month, Day, Year) 27. Manner of Death 1 Natural 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 5 Pending death. 2 Accident investigation 1 ☐ Yes 2 ☐ No hin 24 hours after death the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical d title o 29c. License number 29d. Date signed (Month, Day, Year) 2 29b. Signatur D16364 August 26, 2008

State Registrar 30

ne and address o

Year.

31. Date filed (Month, Day,

DHMH 17 Rev 1/2001

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 23,28a-f per me, g882,08/128/08dhb Mental Hygiene Certificate of Death Reg, No. 1. Decedent's Name (First, Middle, Last, 2. Date of Death Month Day **Physician** Year OUDIIN 15:21 2D1 27 2008 /Medical 4a. Facility Name (If not institution, give street and number)

Good Samasitan Hospital

5. Social Security Number 6. Sex 7. Age (In yes. last bi 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore If Under 1 Year | If Under 24 Hrs. (In yrs. last birthday) 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** (Month, Day, Year) 2-18-1918 1 M 2□F -07-5323 Director Usual Residence of Decedent with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Nes 2 No **Funeral Director** timore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Yes 2 No If Yes, Give Year or Dates: 1 Never Married Married Maryland 21215-0036 1 ☐ Yes No Specify: δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Sedondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be JOHN JOHN 1eps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9a. Infort ant's Name/Relationship (Type. Print) 100·MD Baltimore, Method of Disposition 1 Burial 2 □ Cremation 3 Removal from State Owings Mills, MI) 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee sera Balto MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** RIGHT SUBDI Due ((or as a consequence of): SUBDURAL HEMATOMA /Medical PAROVED BY MEDICAL EXAMINER **Examiner** Sequentially list conditions, if any cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of The law requires that the death certificate be executed nding physician and CERTIFIC Due to (or as a consequence of) 234/35/37/3897 Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown BLEED INTRACEREBRAL MIDLINE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes V☐ No 24a. Was an TRANSTENTORIAL HERNIATION autopsy performe or Attending Physician: certific 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 217 No Mpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1
Natural 5 Pending investigation **Unknown**^M Unknown 1 🗌 Yes 2 **X**Vo Unknown 2 ☐ Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)
Unknown 28f. Location (Street and Number or Rural Route Number, City or Town, State) **Unknown** 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) D'SOUZA , Loch Raven Blud 5601 Baltimore CAROLINE 31. Date filed (Month, Day, Year) . Registrar's Signature State AUG 28 Registrar

			For Amend Items State Registrar	23 State of Mai	ryland/[epartment c per me Certificate	g Bealth of Death	8/28/6 h	atal Hyg 8 dhb	giene Reg. No.	2008	27830			
	Physici		1. Decedent's Name (First, Middle, La	ter				2	Date of De	ath Day	1 a Year	3. Time of Death			
	/Medic		4a. Facility Name (If not institution, giv		, Harri	4b. City, Tov	vn, or Location	n of Death			County of Death	1 1			
	Funeral		University S 5. Social Security Number 6.8	pecialty Sex 77. Age	(In yrs. last bir			er 24 Hrs. 8.	Date of Birt		1/timo	npiace (State or Foreign			
• •	Director		210-30-	1□M 2127F	86	Yrs. Months D	ays Hours	Min.	(Month, Da	y, Year)	Cot	MD			
	land ow		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location			•			10d. Inside City Limits			
	a-f sh	ctor	MD Baltim	ore	Reis	terstown						1 ☐ Yes 2 No			
	with th	Director	10e. Street and Number	_		10f. Zip Co			1	10g. Citiz	en of What Co	untry?			
	ns 23 must	Funeral	12 Sacred Heart	12. Was Decedent Ev	ver in U.S.	13. Was Decedent	21136 of Hispanic (Origin? (Specif	y Yes or No	- 1	USA 4. Race - Amer				
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In portant: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 ☐ Never Married 2 🔀 Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give	0	If Yes, specify 1 ☐ Yes 2X			can, etc.)		Black, White Specify:				
Maryland 21215-0036	2 hours	ed by	3 Widowed 4 Divorced	Year or Dates:	16a.	Decedent's Usual O	ccupation				B.	lack ndustry			
215	ithin 72 le. lan "na Medil	Completed	(Specify only highest grant Elementary/Secondary (0-12)	ade completed) College (1-4or 5+)	-)	(Give kind of work a life. DO NOT use r	,	ost of working							
121	Hygier Hygier ther th nt, the		7 17. Father's Name (First, Middle, Lasi	t)		Housew		ther's Name (F	irst Middle	Maiden S		Home			
lanc	fental I fental I rked of	To Be	James Curles	,				Rovina		, mandon c	Jumamoy				
lary	2 shou and N is mai		19a. Informant's Name/Relationship	(Type. Print)	19b	. Mailing Address (St	reet and Nun	nber or Rural F	Route Numb	er, City or	Town, State, 2	ip Code)			
e, Z	1 and Health em 27 other tr	. 3	Bernard H. Carte 20a. Method of Disposition	r, Sr. Hush	20b. Place of	Disposition (Name of	of	Lane, R			n, MD	21136 Town, State			
Baltimore,	Pages nent of H ant: If ite ury or of		1 XBurial 2 □Cremation 3 □ 4 □Donation 5 □ Other (Speci			ry, crematory or othe ukes Cemet	, i	8/2/0	8			town, MD			
3alti	p.rmit. Page Department of Irr portant: If any injury or once		21. Signature of Funeral Service Lice	nsee	1 0 0 0	22. Name and A	ddress of Fac	cility	11824	4 Rei	sterst	own Road			
3	007 8 9		23a Part 1 Enter the disease or con	Trui	the death. Do	Eline Fu					own, MI	21136 Approximate			
5,6	Physician	/	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Imprediate Cause (Final tease or condition that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
	/Medical		resulting in death)	Due lo (or as a	consequence	of):	.0.^					/ /			
7	Examiner	Į.	Sequentially list conditions, if any, leading to immediate	b. Sue to lor as a	consequence	nf)·					EN EINE	EP 12 hours			
É	executed n and ial-transit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events	Respi	in ton	Laily	wo.			-OVED BY	MEDITAL	21 day 5			
360	cate be executed physician and the burial-transit		resulting in death) Last	Due to (or as a	consequence	Multip	le Inj	uries	CCATION APP	In	MEDICAL ENAME	2-1			
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90 80	th certii ending	an/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome po		3 □Ectopic pregr	anou			2	3d. Date of deli	very			
#0	w requires that the death certific been signed by the attending p should be detached for use as	Completed by Physician/Me	in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknowh	4□Pregnant at ti 9□Unknown		5 ☐ Other (special					Month	Day Year			
30.	that the	y Ph	Part II. Other significant conditions	contributing to death but	t not resulting in	the underlying caus	e given in Par	rt I.	23e. Did t	obacco us	se contribute to	the cause of death?			
Spice	equires en sign ould be	q pa	Atrial Fibrille	-tion					10	Yes 2	¶No 3□Pr	obably 4 Unknown			
3ec	e law r has be e 2 sh	nplet							24a. Was autoj	psv	prior to c	topsy findings available completion of cause of			
talF	vysician: The law his certificate has b director, page 2 s		25. Was case referred to medical					(D. II) (1□ Yes	ormed? 2 □ No	death? 1 ☐ Yes	2 □ No			
r Ķ	iysicia iis cert directe	o Be	examiner?	Hospital: 1 npatient	it 2 ☐ ER/Ou	tpatient 3 DOA	Other:	ace of Death (C Nursing Home			☐Other (Spec	cify)			
Division or Vital Records,	Ing Ph	on: T	27. Manner of Death 1 □ Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 28b. 1	ime of niury 28c.	Injury at Work?	280 Di	d. Describe l	how injury	occurred Sun a veh	bject icle that			
/isid	Attend r death sctor:	Certification:	Accident investigatio 3 Suicide 6 Could not b	01/05/20	00	rm, street, factory, of arking Lo	1∐Yes 2) f <u>i</u> ce				ilding. Number or Ru				
Dİ	rs after ral Dire	Certi	4 E l'idillicide	theister	s town.	MI) - str		7	C(2) e	3/00	m /MS	ral Route Number, tler Road Glyndon,MD			
	To the Hospital or Attending Physician: The law requires that the death certifuln 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	29a. Certifier (Check only one) 1 ★ Certifying Pl 2 ★ Medical Exa	hysician: To the best of miner: On the basis of e and manner state	examination an	e, death occurred at t d/or investigation, in	he time, date my opinion, c	and place, and death occurred	d due to the at the time,	cause(s) date and	and manner as place, and due	stated. to the cause(s)			
_	To the vithin To the complete	Me	29b. Signature and title of certifier	111.		29c. Li	cense numbe	er		29d. Date	e signed (Month	h, Day, Year)			
	F.)		Com 1	7			6189	62		07	124/2	008			
	(6)		30. Name and address of person who	completed cause of dea	ain (Item 23a) (60 (Type, Print) S. Chan	es St	reet	Balt	imen	E MO	21230			
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2.8 2	32 Registrar	r's Signature	Coaste									

08-06515	
Allan Cohen	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hydiene

Miai	Conen		1- For State Registrar Certificate of Death		Reg. No. 200	8 2783
	Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of De	ath	3. Time of Death
Me¢ ,∵	dical Examii		Alan Cohen 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	Month August 2	5, 2008 4c. County of Death	2104 hrs
			283 Clay Road Laurel		Anne Arundel	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Months Days Hours I	Hrs. 8. Date of B	irth(MM/DD/YYYY) 9. Bir Foreig	
	Director		267-37-9879 1 XM 2 F 50 Yrs.			ountry) MA
	any	-	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
	≹ ,,	5	MD Anne Arundel Laurel			1 Yes 2 No
1	Marylar 28a-f	Director	10e. Street and Number 10f. Zip Code		10g. Citizen of What Cou	ntry?
1	ith the 23a or notifie	a Ö	283 Red Clay Road, #303 20724 11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin?	/ Specify Ves or N	US 14 Race - Amer	SA ican Indian, Black,
2	leath w	Funeral	1 Never Married 2XX Married 2XX Married 1 Yes 2 X No		White, etc.	roan maian, Didok,
k	after de	by F	or Dates:			nite
0	hours "natur	Ed.	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind during most of working life. DO NOT use		16b. Kind of Business/	Industry
	036 ithin 72 ne.	Completed	12th 2 Chef		Restaura	int
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.				, Maiden Surname)	
	212' uld be Mental marke	To Be				e, Zip Code)
	MD and 2 shoulth and m 27 is aumafie		Marlene Beth Cohen/Wife 283 Red Clay Road,	#303		20724
	or Fred Heal	ı	20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City or	Town, State
	Baltimore, permit. Pages I an Department of Hes Important: If ite		4 Donation 5 Other Specify: West Arundel Crem. 8,	/27/2008	Odenton,	
	Balt permit. Departs Import		21-Signature of Funeral Service Licensee 22. Name and Address of Facility M01103 313 Talbott Aver			
	Physician		23a. Por I/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardinality. List only one cause on each line.			Approximate Interval Between Onset and
	/Medical xaminer	1	Imm the Cause (Final disease a. Hypertensive atherosclerotic cardi	ovascu1a	r disease	Death
	2		b			
		je.	Sequentially list conditions, if any leading to firm a sequence of cause. Enter Underlying Cause			
		Examine	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):			
	xecuted n and - trans			T		-
	760, ficate be executed g physician and the burial - transit	Medical	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	
	687 certifica iding pl	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death 3 Ectopic pre	egnancy		Day Year
	Box 687 e death certific the attending of for use as the	Physician/	1 Yes 2 No 9 Unknown 4 Pregnant at time of death 5 Other (Specify)			
	, P.O. Box 687 ires that the death certification by the attending is be detached for use as the	by Ph			tobacco use contribute to	
	Division of Vital Records, P.O. Into Attending Physician: The law requires that the stater death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detaced.	a pa		1Y 24a. Wa		utopsy findings available
	Vital Records, ysician: The law requirents certificate has been selficete, page 2 should	Completed		aut		completion of cause of
	Red: The liftcate r., page			1 ✔ Yes	2 No 1 Y	es 2 No
	Vital Rehysician: The this certificate	To Be	examiner? [Hospital:	ursing Home 5	Residence 6 🗸 Othe	er: Scene
	ing Ph After t Suneral				e how injury occurred	
	ivision or Attend after death Director:	Certification:	1 X Natural 5 Pending 1 Yes 2 No large Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	1000	(Street and Number or R	ural Pouto Number City
	Divi	틸	3 Suicide 6 Could not be determined (Specify)	or Town,		urai Route Number, City
	Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi					
	To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurr and manner stated. 29b. Signature and title of certifier 29c. License number	ed at the time, dat		
		-	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (Me August 26, 2008	-
			30. Name and address of person who completed cause of death (Item 23a)			
			Russell Alexander MD. Assistant Medical Examiner 111 Penn Street, Baltimore	, MD 21201		
	St Regist	ate rar				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 430 A Carric 2008 4a. Facility Name (If not institution, give street and number) Town, or Location of Death 4c. County of Death Bullneck IH MORE Birthplace (State or Foreign Country), Onio 8. Date of Birth (Month, Day, Year) 7-18-1926 5. Social Security Number Age (In vrs. last birthday) 11∆ M 2□ F Months Days Hours Min. 214-22-5935 Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 XYes 2 ☐ No Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8272 Bullneck Road 21222 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Bace - American Indian. Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 □Yes 21 No White If Yes, Give Year or Dates: WWII Specify 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Armco Machinist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

20b. Place of Disposition (Name of cemetery, crematory or other place)

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause are chiline.

aditions contributing to death but not resulting in the underlying cause given in Part I.

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

pronic

Due to (or as a consequence of):

Due to for as a consequence of

Due to (or as a consequence of)

23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death

28a. Date of Injury (Month, Day, Year)

120

2008

32. Registrar's Signature

9 🗆 Unknown

B 100 B

Hospital:

5 Pending investigation

6 Could not be determined

30. Name and address of person who completed gause 32

Year)

Oak Lawn Cemetery 8-29-08

3 Ectopic pregnancy

28c

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

EASKRY AVE

5 Other (specify)

Mary Legnowska

PA, 2134 Willow Spring Rd, 21222

22. Name and Address of Facility Bradley-Ashton Funeral Home

24a. Was an 1 ∐ Yes

26. Place of Death (Check only one)

Other: 4 \(\sum \) Nursing Home

1 ☐ Yes 2 ☐ No

2 No

28d. Describe how injury occurred

5 Residence 6 ☐ Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

20c. Location - City or Town, State

Baltimore, MD

23d Date of delivery

Day

3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No

Month

23e. Did tobacco use contribute to the cause of death?

Approximate Interval Between Onset and Death

100 5

Year

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8245 Bullneck Rd, Dundalk, MD 21222

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural" --- any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every any injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every and injury or other traumatic every ever **Physician** /Medical Examiner P.O. Box 68760, or Attending Physician: The law requires that the death certificate be Records, of Vital Division after death. e Funeral I Hospital

physician and s the burlal-transit

Physician

Examiner

Funeral

Director

/Medical

10a. State

MD

Director

Funeral

<u>ک</u>

Completed

Be

ဂ

Examiner

Completed by Physician/Medical

Be

Medical Certification: To

the funeral

Peter Carrick

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

1 ☐Yes 2 ☐ No

9 Unknown Part II. Other significant of

in the past 12 months?

25. Was case referred to medical examiner?

29b. Signature and title of certifier

1 Yes 2 No

27. Manner of Death

Natural 2 Accident

3 Suicide

29a, Certifier (Check only one)

4 Homicide

disease or condition resulting in death)

IF FEMALE:

19a. Informant's Name/Relationship (Type. Print)

4 ☐ Donation 5 ☐ Other (Specify)

21. Signature of Funeral Service Licensee

Jerri Shahverdi - Daughter

1 Burial 2 □ Cremation 3 □ Removal from State

completely filled in by

DHMH 17 Rev 1/2001

Registrar

death (Item 23a) (Type, Print) Bayview Me

			1 - For State Registrar	State of Marylar		artment of I rtificate of		and Me		jiene eg. N2	008	278	33
	Physici	_	1. Decedent's Name (First, Middle, Las Kenneth L. Cubb	,					2. Date of Dea Month AUGUST	Day	Year 2008	3. Time of 2246	Death M
	/Medic		4a. Facility Name (If not institution, give			4b. City, Town,	or Location o				ounty of Deat		
es.			Western Md Healt			CUMBER		04 Has T 6	2 5 1 1 1 1 1 1		LLEGAN		
	Funeral		5. Social Security Number 6. S 216-22-6337	ex 7. Age (In yrs. ▼ M 2□F		If Under 1 Year Months Days	If Under 2 Hours	Min.	3. Date of Birth (Month, Day	, Year)		hplace (State ountry)	r Foreign
-	Director		Usual Residence of Decedent	0	J			F1	ar 22,	1920	Mai	yland	
	tryland thow	.	10a. State 10b. County		ty, Town or Lo							10d. Inside Ci	,
	he Ma 8a-f s	Director	MD Allegany	Co	rrigan					Ina Citiza	n of What Co	1 ☐ Yes	-X-110
	with the		10e. Street and Number 11002 Poorbaugh	Avenue		10f. Zip Code 2	1524			rog. Cilize	USA	untry :	
	e filed within 72 hours after death with the Maryland at Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examiner must be notified at	Funeral	11. Marital Status	12. Was Decedent Ever in L	J.S. 13.	Was Decedent of If Yes, specify Cul	Hispanic Ori	gin? (Spec	ify Yes or No-	14	. Race - Ame		
9	after or ite		1 ☐ Never Married 2X Married	Armed Forces? 1 ☐ Yes 2 X No If Yes, Give		1 ☐ Yes 2X No			icari, etc.)	1	Black, White pecify: wh		
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5	in 72 "nat	Completed	15. Decedent's Ed (Specify only highest gra	nde completed)	(Give	kind of work done DO NOT use retire	during mos ed)	t of working	g	IOD. KING	Of Business/	industry	
212	d with giene. ir than	E	Elementary/Secondary (0-12)	College (1-4or 5+)	sı	ıpervisor	•			tir	e comp	any	
2	tal Hy	Be C	17. Father's Name (First, Middle, Last,					,	(First, Middle,	Maiden St	urname)		
<u> </u>	ould to	은	William Justice		T				th Loy				
Mar	nd 2 sh Ith and 27 Is rr r traum		19a. Informant's Name/Relationship (Betty Cubbage/sp			ng Address <i>(Stree</i> 2 Poorbau							
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notifiled at once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specif	Removal from State		osition (Name of matory or other pla	ace)	Da	ite	20c. Loca	ition - City or	Town, State	
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	Physician	Ш	Immediate Chuse (Final disease or con Tion	a. Gastroin Due to (or as a conse	testi	nal B	leed	ding				Onset and	Death
•	/Medical Examiner	Ш	resulting in death)	Due to (or as a conse	quence of):			-	3				
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387	icate b physic s the b	dical		▲d,									
Box 6	certifi nding use as	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pregr						23	d. Date of de	liverv	
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	s that ned b e deta	by Pt	Part II. Other significant conditions	contributing to death but not re	sulting in the u	underlying cause g	iven in Part I	l.	23e. Did to	obacco use	e contribute t	o the cause of	death?
Vital Records,	w require been sign should b	led k	CRI, Chronic.	Aremia, Pan	hypof	ituita	risn	2	1 🗆 1	res 2	No 3□P	robably 4 🗌	Unknown
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ō	Physer this eral di	To	1 ☐ Yes 2 ☐ No 27. Manner of Death	28a. Date of Injury	28b. Time	ALL SOLDON	4 LJ NI		ne 5 Resid			ecify)	
<u>o</u>	Attending Physician: r death. ector: After this certifics by the funeral director, p	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day Year) n	Injury		ork? ⊒Yes 2□	No					
Division or	al or Atte s after des Il Directo d in by th	Certification:	3 Suicide 6 Could not b 4 Homicide determined		nome, farm, si	treet, factory, office	9	2	8f. Location (8 City or Tox	Street and vn, State)	Number or Fi	ural Route Nur	mber,
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical C		hysician: To the best of my kr miner: On the basis of examir and manner stated.									(s)
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7				- N Clair	Teus		1004	167		AUGU	JST 2	1, 2008	
			30. Name and address of person who			Print)	Α	C	\	B	2.5	2 2	
	St	ate	31. Date filed (Month, Day, Year)	Registrar's Sign		Sylvani	arve	, (rwper	land	IMD.	1150	
	Regist		Alig 2 9 20	118 Paris	T 140								

Please Type or Print in Plack hydelitie Int. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 1153 PM EMMA CURETON August 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Medical Center Baltimore Cit If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days Hours Vear) 1 M 2 F Director 74 SOUTHCAROLINA 5905 61 11,1946 Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show ed other than "natural", or Items 23a or 28a-f show event, it e Medical Examiner must be motified at Director 1 √Yes 2 No MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? within 72 hours after death with 1212 N. ENSOR ST. 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: -Never Married 2 Married Baltimore, Maryland 21215-0036 1 □Yes 2 □ Nyo Specify: ð Specify: BLACK 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECRETARY TELEPHONE CO. 12th is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be innent of Health and Mental HENRY LEE MC COY ESTHER ERVIN 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 s
Department of Health ar
Important: If Item 27 is
any injury or other trau JACQUELINE ANTHONY (daughter) 533 N. Robinson St. Balto, Md. 21205 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) KING Memorial Pk. Sept.3,2008 BALTO,MD. gueture of Funeral Service Licensee CALVIN B. SCRUGGS FUNERAL HOME PRESTON E. ST. BALTO, MD. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** cancer Lung disease or condition resulting in death) /Medical Due to ar as a consequence of): Examiner 6 weeks Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): executed and burial-trar Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician: The law requires that the death certificate be Physician/Medical the as IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🗷 No Day Year 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ pe 1 X Yes 2 No 3 Probably 4 Unknown Completed peen 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed' certificate 2 □No 1 ☐ Yes 2 🕱 No 1 XYes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred or Attending 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident hours after death uneral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one)

To the Hospital within 24 hours a To the Funeral C

State Registrar

31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

Mercy Medical kirsten

ddress of person who completed cause of death (Item 23a) (Type, Print)

Center, D.O.M. 32 Registrar's Signature

Kirsten Baca, MD

29c. License number

AM 2556996 259

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No.2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year 1:54 PM Venti ichae /Medical 4a. Facility Name (If not institution, give street and numbe 4b. City, Town, or Location of Death Examiner 4c. County of Death nion Memorial 7. Age (In yrs. last birthday) If Under 24 Hrs. 6. Sex 1 M 2 □ F If Under Social Security Number 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Months Hours Min. Year) Days 212-10-2350 9 Yrs. Director pet 5, 1916 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show ral", or items 23a or 28a-f shov Examinar must be notified at Director 1 Yes 2 No MD Itimore 10e. Street and Number 10g. Citizen of What Country? 21213 Funeral states Inited 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Myes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White Specify Completed by 3 ☐ Widowed 4 ☐ Divorced "natural" 7 is marked other than "nature traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Arco Concrete Elementary/Secondary (0-12) College (1-4or 5+) iompany 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be hillip ၉ Dalvi 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a item 27 other to Iheresa altimore MD 21213 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Department of Important: If it any injury or o 1 ☑ Burial 2 ☐ Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Saltimore, mD. -2-08 Signature of Funeral Service Licensee 22. Name and Address of Mollity
Evans Funeral Chapel + Cremation Services
3500 Harford Rd Parkville MD 2123 ackulle MD 21234 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between gnset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence a) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Day Month Year 5 ☐ Other (specify) cate has been signed by the page 2 should be detached 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 🗆 No 2/☑No 1 TYes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes % No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No after death Director; filled in by the 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

MOIM

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year) AUG 2 9 2008

Amend #30 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 25, 2008 AUGUST Physician 8:05 PM BEVERLY KLEIMAN DAVID /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner MONTGOMERY SUBURBAN HOSPITAL BETHESDA 8. Date of Birth Month, Day, Year) 11/30/1922 5. Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex Age (In yrs. last birthday) Funeral Months Days Hours Min. 1 □ M 2 💢 F 85 217-12-3881 MD Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10a. State 10b. County 10c. City, Town or Location 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marked Examiner is as the motified at once. 1 ☐ Yes 2 X No MD MONTGOMERY ROCKVILLE Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 6121 MONTROSE ROAD USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 📉 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married WHITE Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates Specify Specify. þ 3 X Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be BENJAMIN KLEIMAN REBECCA PARISER မ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) RICHARD BISHOW / SON 6911 SAINT ALBANS ROAD MCCLEAN, VA 22101 20b. Place of Disposition (Name of cemetery, crematory or other s Date 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State ARLINGTON CHIZUK AMUNO 8/28/2008 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final NEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CHOLECYSTITIS ACUTE Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed nding physician and ise as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ Yeb 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? Yes 2.2 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∐ Yes 2 No 1 ☐ Thpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 🖼 Natural 5 Pending 1 □Yes 2 □No within 24 hours after death. To the Funeral Director: A 2 Accident investigation I Director: / 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 🕯 free tifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 00057124 8126107 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Truong Bao 10110 Molecular Dr. # 206 Rockville, MD 20850 31. Date filed (Month, Day, Year) State Registrar

08-06492 Jeffrey Ellis Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

27837 2008

		- For State			-		Certific	cate of	Death					Reg. No	D	. 0 0		
Physicia		egistrar 1. Decedent's Name	e (First, Midd	le,Last)									. Date of De Month	Day	Year		3. Time of	
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		4a. Facility Name (i	f not institution	on, give st	reet and nu	mber)		4	. City, Tow	vn, or Lo	cation of	Death		ľ	4c. County o			
	ш	Baltimore V	Vashingto	n Medic	al Cente	er			Glen Bu	Jrnie					Anne Aru			
Funeral		5. Social Security N	Number	6. Sex		7. Age (I	n yrs. last b	irthday)	If Under		If Under		8. Date of	Birth(MI	M/DD/YYYY	9. Birtl Foreigi	hplace (Sta	ate or
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21215-0036 Jud be fited within 72 hours after do Mental Hygiene. Manaked other than "natural", or cevent, the Medical Examiner m	0	19a. Informant's N		nship (Typ	e, Print)			19b. Mailing	Address	(Street	and Num	ber or R	lural Route I	Number	, City or Tow	vn, State	a, Zip Code	e)
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and and lealth		20a. Method of Di	sposition					ce of Dispos	ition (Name				Date	20	oc. Location	- City or	r Town, Sta	ate
altimore, MD 21215-0036 mit Pages I and 2 should be filed within 72 hours after death with the Maryland apartment of Health and Mendel Hygiene. spartment of Health and Mendel Hygiene of the Arman "matural", or items 23a or 28a-1 she iury or other traumatic event, the Medical Examiner. must be notified at once			X)Cremati		Removal	from State	7	iew Crε		,		Aug	27, 200	28	Baltime	ore.	MD	
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Baltimore, MD 21215-003 permit. Pages ! and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other thingury or other traumatic event, the Med			0000	. A.U.)		104410		i F	ink Fu	inera	 Home 	e. P.	A.	: a h	MD 210	C1		
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Box 687 The death certifice the attending property the attending property that the attending property that the attending property that the attending property that the attending property that the attending property that the attending property that the attending property that the attending property that the attending property that the attendence the attendence the	155	1 Yes 2		Unknown		-	ime of death	5 C	ther (Spec	cify)				_				
BC he dez	Physician	Part II. Other sig				known	but not resi	ulting in the	underlying	cause o	iven in P	art I.	23e. I	Did toba	acco use con	ntribute f	to the caus	e of death?
r, P.O. ires that the signed by it be detached	by F				COMMIDUM	y to death	DUCTION	onthing in the	didonying	30000	,		1	Yes	2 No :	3 🗸 Pr	obably 4	Unknown
S, F uires n sign Id be		II. Diabe	tes mellitu										24a. \	Was an	24b			dings available
cords, law requir has been s	l set													autopsy perform		prior to death?		on of cause of
Vital Records, hysician: The law requiruhis certificate has been si director, page 2 should b	Completed													res 2		1 🗸		2 No
tal Rection: The certificate ector, page	0	25. Was case re	ferred to med	lical						26.Place		(Check	only one)					
Vital ysician: his certifi director,	0 8	examiner?	2 No	H	ospital: 1	Inpatier	nt 2 🗸 E	R/Outpatie	nt 3 🔲 🛭	OOA	Other:	Nursi	ng Home	5 R	esidence 6	Oth	ner:	
n of \ding Phy. After tl	⊢	27 Manner of De			28a. Da	ate of Injur	ry 2	28b. Time of	Injury	28c. Inju	ry at Wor	k?	28d. Desc	ribe ho	w injury occi	urred		
ion tendin eath.	5	1 V Natural		ending		Jikii, Duy, I'e	1			1	Yes 2	No						
Division tal or Attendir rs after death. at Director: A	1 2	2 Accident 3 Suicide	-	nvestigatio Could not b	28e P	lace of Inj	ury - At hon	ne, farm, str	eet, factory	, office I	building, e	etc.		tion (Str		nber or	Rural Rout	e Number, City
Divi spital or ours afte teral Dir	ertification:	3 Suicide 4 Homicid	d	etermined		ify)							0, 10	WII, Oto				
	၂ပ	29a, Certifier	Cortifuin	g Physicia	an: To the	best of my	y knowledge	e, death occ	urred at the	e time, d	ate and p	lace, an	d due to the	cause	(s) and manr	ner as s	tated.	
To the Hos within 24 h To the Fur	Medical	one) 2	✓ Medical I	Examiner	On the bas	sis of exar	mination and	d/or investig	ation, in m	y opinio	n, death o	ccurred	at the time,					
F 3 F 8	S	29b. Signature a	and title of ce	rtifier					29	c. Licen	se numbe	eΓ			29d. Date si			, Year)
-		2) 6- Y	m	SIL	IMD				O.C.	.M.E.				August 2	5, 200	38	
1		30. Name and a	ddress of per	rson who	completed of	cause of d	eath (Item 2	23a)					*					
5		111	. Vincenti,				al Exam		11 Penn	Street	t, Baltin	nore, I	MD 2120	1				
	State					69	r's Signatur	e	resk	9								
Regi	stra	<u> </u>	AUG ?	<u> 3 9 2</u>	1800	Fleee	63.1 A	250										
DHMH 17 Rev 1	/2001	r .			•			ORIGIN	AL									

27838

State of Maryland / Department of Health and Mental Hygiener 1 - For State Registrar Certificate of Death

Reg. No.

Dhysisian
Physician
/Medical
Examiner

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, Ita Modical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician √Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

an	1. Decedent's Name (First, Middle, Last)			2. Date of Death Month	Day Ye	ar 3. Time of Death
al	MARINDA EVANS			AUGUST 2	27, 2008	12:09 P. [™]
er	4a. Facility Name (If not institution, give street and number)		r Location of Death		4c. County of D	
	5.59 NEW PITTSBURG AVENUE 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	TURNER S	STATION If Under 24 Hrs.	8 Date of Birth	BALTI	MORE Birthplace (State or Foreign
	1 □ M 2 👿 F Vre	Months Days	Hours Min.	8. Date of Birth (Month, Day,		Country)
	215-24-1385 93 Usual Residence of Decedent			08-28-19	114	VA
	10a. State 10b. County 10c. City, Town or L	ocation				10d. Inside City Limits
ģ	MD BALTIMORE TUI	RNER STAT	LON			Yes 2 □ No
ie	10e. Street and Number	10f. Zip Code	LON	10	g. Citizen of What	Country?
Funeral Director	559 NEW PITTSBURG AVENUE		21222		USA	
ner		. Was Decedent of H		ecify Yes or No-	14. Race - A	merican Indian,
F	1 X Never Married 2 Married 1	1 ☐Yes 2 No	Specify:	nican, etc.)		/hite, etc.
d b	3 ☐ Widowed 4 ☐ Divorced Year or Dates:	1	оресну.		Specify:	BLACK
Completed by	(Specify only highest grade completed) (Give	edent's Usual Occup	during most of work	ina 1	6b. Kind of Busine	ess/Industry
Id II	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired	d)			
ဒ္	7COO	OK				STUARANT
Be	17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, M	aiden Surname)	
2	BOOKER VENABLE		LIZZY		- <u>-</u>	
		ling Address (Street			•	
		NEW PITTS		-		
	20a. Method of Disposition 1 ★ Burial 2 ☐ Cremation 3 ☐ Removal from State	oosition (Name of ematory or other plac	ce)	Date 2	0c. Location - City	or Town, State
	4 Donation 5 Other (Specify) ARBUTUS	MEM. PK		1-2008 I	BALTIMORE	E, MD
	21. Sign ture of Funeral Service Licensee	22. Name and Addre	ss of Facility JAM	ES A. MO	ORTON & S	SONS F.H., INC
	James G. Water	1701 L	AURENS ST	., BALTO.	, MD 212	217
	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dyir	ng, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Immediate Cause (Final disease or condition	100 con	dal	List	unch	Onset and Death
	resulting in death) Due to (or as a consequence of):	1 .1		0		1
	Sequentially list conditions b.	U Lle	nd &	e se	-	glas
ner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying	1				
Examine	that initiated events	fleer				year
Ĕ	resulting in death) Last Due to (or as a consequence of):					0
ician/Medical	d					
Med	IF FEMALE:					.1.
au/l	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	Ectopic pregnanc	ev.		23d. Date of	
sici	1 Yes 2 No 4 Pregnant at time of death 5	Other (specify)			Month	Day Year
Physi	9 LI ONKHOWN					
by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause giv	en in Part I.	23e. Did toba	acco use contribut	e to the cause of death?
pe	- aria	****		1 ☐ Yes	s 2∐No 3∐	Probably 4 Onknown
Completed by				24a. Was an		e autopsy findings available
ΕÓ				autopsy perform 1 □ Yes 2	ed? deat	to completion of cause of h? Yes 2 □ No
Be C	25. Was case referred to medical		26. Place of Deat	th (Check onl. one		.00 2010
0	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie	ent 3 DOA Oth			nce 6 Other (5	Specify)
L:u	27. Manner Death 28a. Date of Injury 28b. Time	of 28c. Inju		28d. Describe how	<u>`</u>	
atio	2 Accident investigation		Yes 2 □No			
tific	3 ☐ Suicide 6 ☐ Could not 28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office		28f. Location (Str.	eet and Number o	r Rural Route Number,
Cer	building, etc. (Openly)			City or Town,	Diale)	
Medical Certification: To	29a. Certifier (Check only 2 Medical Examiner: On the basis of examination and/or i	ath occurred at the ti	me, date and place	, and due to the ca	use(s) and manne	er as stated.
edic	(Check only one) 2 Medical Examiner: On the basis of examination and/or and manner stated.	investigation, in my o	opinion, death occui	rred at the time, da	ite and place, and	aue to the cause(s)
Ź	29b. Signature and title of cortifier	29c. Licens	e number	29	d. Date signed (M	lonth, Day, Year)
	MUULLONG	DO.	0835	8	AUG Z	9 2008
	30. Name and address of person who completed cause of death (Item 23a) (Type	e, Print)	0	002 4	NOFO	RP ROLD
	GRACITY X, VATTO	Zicio	1835 Fa-08	7 / 7	KANO	12311
te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		t	4 CT	170/ 61	14
ar	AUG 2 9 2008 Seven & Span	de la				
001		-				

Registrar

			1 - For State Registrar	State of	Marylar		artment of rtificate of				iene og. No. 0 (08 27	839
	°o		Decedent's Name (First, Middle, La	st)			Timodio o	204111		. Date of Deat			of Death
	Physici /Medio		Elizabeth F.	Fee						Month Aug.	26, 20	008 10:	45AM
	Examin		4a. Facility Name (If not institution, given Manor Care Ru		nber)		4b. City, Town,		of Death		4c. County Balt		
	Funeral Director		5. Social Security Number 6. S 215-48-1063	ex □M 2 X F	7. Age <i>(In yr</i> s. 96	last birthday) Yrs.	If Under 1 Yea Months Days		24 Hrs. 8 Min. 1	Date of Birth (Month, Day, 1/13/1	Vear) 1911	9. Birthplace (State Country) MD	or Foreign
	D		Usual Residence of Decedent		1.0.0								
	show	7	MD Baltim	ore		ty, Town or Lo	ocation					10d. Inside	City Limits as 2 No
	28a-f	rect	10e, Street and Number				10f. Zip Code			1	0g. Citizen of V		
	death with the Maryland ms 23a or 28a-f show	ai Di	612 Worcester	Rd.			212	86			USA	·	
	r deat	Funeral Director	11. Marital Status	Armed Fo		J.S. 13.	Was Decedent of	Hispanic Or ban, Mexica	rigin? (Specif n, Puerto Ric	fy Yes or No- can, etc.)		e - American Indian, ck, White, etc.	
0030	hours after tural', or ite	by Fi	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	1 □Yes If Yes, Giv Year or Da	9		1 ☐ Yes 2 🗷 N	Specify:			Specify	white	
ž	thin 72 hours after death with the Marylar e. en "naturat", or items 23e or 28e-f show Medical Examinat must be motified at	ted	15. Decedent's E.	ducation		16a. Dece	dent's Usual Occi	upation	ot of working		16b. Kind of Bu	usiness/Industry	
2 2	within 72 ene. than "nai	Completed	(Specify only highest gra Elementary/Secondary (0-12)	College (1	-4or 5+)	1	kind of work don DO NOT use retir	ed) ed)	st of working	1	Own H	ome	
7	illed withlr Hygiene. other than	Co	12 17. Father's Name (First, Middle, Last,)		Home	emaker	18. Moth	er's Name (/	First, Middle, M	Maiden Surnam		
/land	lid be lenta ked ic ev	To Be	Jacob Frey						abel			,	
Mary	s 1 and 2 should f Health and Men item 27 is marke other traumatic		19a. Informant's Name/Relationship (Herbert T. Fee		Son	19b. Mailii 612	ng Address (Stree 2 Worce	ster	Rd.	Route Number Towsor	City or Town,	State, Zip Code) 21286	
ore,	ss 1 and of Health litem 27 r other ti		20a. Method of Disposition	`D16		Place of Dispo	osition (Name of matory or other pi	ace)	Dat	9 7	20c. Location -	City or Town, State	
artimor	Pages ment of ant: If it		1 Burial 2 □ Cremation 3 □ 14 □ Donation 5 □ Other (Specif		State	uid Ri	ldge Ce	m.	2008	· ∠, l	3altım	ore, MD	
Dall	permit. Pages Depirtment of I Important: If it any injury or o		21. Signature of Funeral Service Licer	1500	MOIY	143 2	2. Name and Add	ress of Facili	CAFA	/Steph	nen D.	Lohrmann	P.A
	40240		23a. Parti. En er the disease, or com shock, or heart failure. List only	plications that c	aused the dea							. Md 212	
	Physician		Immediate Cause (Final		AN 1							Interval B Onset an	letween
	/Medical		disease or condition resulting in death)	a	or as a consec	quence of):		_				3 user	
	Examiner		Sequentially list conditions,	b. DE	MEV		- ALZ	1/2	ME	125		3 uc	15
	ted sit	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):						0	
<u>,</u>	execunand and ial-train	Examiner	that initiated events resulting in death) Last	Due to (or as a consec	quence of):			· · ·				<u> </u>
Q/20	certificate be executed nding physician and use as the burial-transit	dicai		d					-				
Ó	ertifica ding pt	Med	IF FEMALE:	220 16 100 014									
ğ	attend for us	cian	23b. Was decedent pregnant in the past 12 months?		inth 2 □ Feta ant at time of o	al death 3	Ectopic pregnan Other (specify)	су			23d. Dat Mor	te of delivery nth Day	Year
j.	that the death certificated by the attending properties as	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno									
ν, L	w requires that the death is been signed by the atter should be detached for u	by Р	Part II. Other significant conditions of	ontributing to de	ath but not res	sulting in the u	inderlying cause o	iven in Part	l.			ribute to the cause o	
ecords	requir	eted								-		3 Probably 4	Unknown
Zec	The law ate has b page 2 sl	ompleted								24a. Was a autops perforr	v .	Were autopsy finding prior to completion of death?	s available cause of
VItal	vician: The lav certificate has rector, page 2	e Co	25. Was case referred to medical					26 Place	e of Death //		2 2 No 1	I□Yes 2⊡No	
	S .D	To B	examiner? 1 Yes 2 10	Hospital: 1 🗆 I	npatient 2] ER/Outpatier	nt 3 DOA	thorn			ence 6 Oth	er (Specify)	
0	ing Pl	on:	27. Manner of Death 1 ☐Natural 5 ☐ Pending	28a. Date of (Mont	of Injury h, Day Year)	28b. Time o Injury	W			d. Describe ho	w injury occurr	red	
JIVISION	death ctor: /	licat	2 Accident investigation 3 Suicide 6 Could not b		of Injury - At h	ome farm st	M 1[]Yes 2□		f. Location (St	reet and Numb	er or Rural Route No	ımber
2	s after al Direction	Certificat	4 Homicide determined	buildir	ng, etc. (Speci	fy)	root, ractory, office	,		City or Town		0. 0. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	3771007,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	edical	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exer	ysicien: To the niner: On the ba and mann	asis of examina	owledge, deat ation and/or in	h occurred at the vestigation, in my	time, date ar opinion, dea	nd place, and ath occurred	d due to the ca at the time, da	ause(s) and ma ate and place, a	inner as stated. and due to the cause	a(s)
	To th within To th compl	Me	29b. Signature and title of certifier				29c. Licer	nse number		2	9d. Date signed	d (Mopth, Day, Year))
			1					0617			8/2-	7/08	
1	0		30. Name and address of person who	completed caus	e of death (Item	т 23а) (Туре,	Print)	es (5+ ,1	Bo Hr	, MO	21264	
Ì	Sta		31. Date filed (Month, Day, Year)	32. R	egistrar's Sign	ature	2		// 4.		1	/_/	
	Registr	ar	ALIG 2 a 2008	E 35 426 . A	a Kipo	14 13 To 15 C							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			1 - For State Registrar				ertificate of l			Reg. No.	2008	27840)
	Physici	an	Decedent's Name (First, Midd.						Date of De Month	Day	Year	3. Time of Death	
	/Medi	cal			ELDS		T		August	28	2008	02:00 a ^M	_
	Examir	ner	4a. Facility Name (If not institution		ber)		4b. City, Town, or	Location of Dea	th		County of Death		
- Linear			GILCHRIST H 5. Social Security Number		. Age (In yrs.	last hirthday	TOWSON If Under 1 Year	If Under 24 Hrs	8. Date of Bir		BALTIMOF 9 Birtho	RE CO lace (State or Foreign	_
	Funeral Director		215-24-2124 Usual Residence of Decedent	1 □ M 2 X OXF	85		Months Days	Hours Min		ay, Year)	Cour	RYLAND	
	land ow		10a. State 10b. County	,	10c. Cit	y, Town or L	ocation			-	1	0d. Inside City Limits	_
	ith the Marylan or 28a-f show	ģ	MARYLAND BAL	TIMORE			KINGSVILL	T-7			-	1 ∐ Yes 2√CXNo	
	r 28a	Director	10e. Street and Number	THORE			10f. Zip Code	<u> </u>		10g. Citiz	en of What Coun	itry?	-
	h with		10844 PFEFFE	R RD.			2108	7		II	.S.A.		
	deat	Funeral	11. Marital Status	12. Was Deced	ent Ever in U.	S. 13	. Was Decedent of Hi If Yes, specify Cuba		Specify Yes or No		4. Race - Americ		_
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. The file is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinat nust be notified at	by	1 ☐ Never Married 2 ☐ Mar 3 🛣 Widowed 4 ☐ Divorced	If Voc Cive	No XNo		1 ☐ Yes 2 ☒ No		to Hican, etc.)		Black, White, of Specify: BLA		
5-0	72 hc	Completed	15. Deceder	nt's Education est grade completed)		16a. Dec	edent's Usual Occup e kind of work done o	ation during most of wo	rkina	16b. Kin	d of Business/Ind	dustry	
Maryland 2121	filed within Hygiene. other than "	ם	Elementary/Secondary (0-12)	College (1-4	4or 5+)	life.	DO NOT use retired)					
2	2 should be filed withir and Mental Hygiene. is marked other than aumatic event, the M		8th grade	10		HOUS	EWIFE/PIA				RIVATE		_
anc	be fi	Be	17. Father's Name (First, Middle,	Last)			1		me (First, Middle		surname)		
Ĕ	should be fand Mental Is marked of umatic eve	မ	SIMON BROWN			1			ARET BRO				_
Ma	12 sho th and 7 is ma traums		19a. Informant's Name/Relations				ling Address (Street a					,	
e, l	1 and 2 Health em 27 i		Joan Thurman/	Daughter	20h B	1099	8 Pfeffer:	s Rd., K	ingsvill Date		aryland cation - City or To		_
و	97 0		1 X Burial 2 ☐ Cremation		tate 200. r	emetery, cre	osition (Name of ematory or other plac	e)	Date	200. Loc	Zalion - City of 10	wii, State	
Baltimore,	nit. Pagartmen ortant: injury		4 □ Donation 5 □ Other (5		ASE	BURY U			03-08	WHIT	EMARSH,	MARYLAND	
Ba	permit. Page Department (Important: If any Injury or once.		21. Sign were of Funeral Service	Blown			22. Name and Address FUNERAL HO 321 S PHI	PARETHARF	ORBLVB;	ABER		21001 RYLAND	
			23a. Part1. Enter the disease, of shock, or heart failure. List	r complications that car only one cause on eac	used the death ch line.	n. Do not er	nter the mode of dyin	g, such as cardia	c or respiratory a	rrest,		Approximate Interval Between Onset and Death	
1	Physician		Immediate Cause (Final disease or condition resulting in death)	_a. ASA	PIRAT	TON	PNEUN	TONIA				WEEKS	
4	/Medical Examiner		resulting in death)	Due to (o	r as a consequ								
		<u>.</u>	Sequentially list conditions,	b. 3.7	KOKE Fas a our segr	tions of						MONTHS	
8.	ited nsit	ij	Sequentially list conditions, in any, reauting to immediate cause. Enter Underlying Cause (Disease or injury	S Due to to	r as a consequ	acileo ory.							
70	execu al-tra	Examiner	that initiated events resulting in death) Last	c Due to (o	r as a consequ	uence of):							_
68760,	icate be executed physician and the burial-transit												
89	ertificat ing phy e as the	Medical	<u></u>	u									_
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown		rth 2 ☐ Feta ınt at time of d	I death 3	☐ Ectopic pregnancy ☐ Other (specify)	/		2	3d. Date of delive Month	ery Day Year	
rds, P.	w requires that been signed b should be deta	þ	Part II. Other significant conditi	ons contributing to dea	th but not resu	ulting in the	underlying cause give	en in Part I.	11			ne cause of death?	
000	law requ as been 2 shoutc	Completed							24a. Was		24b. Were auto	psy findings available	_
Ĕ	The I	E								osy ormed? 2 ⊊ No	death?	mpletion of cause of 2 No	
ita		0	25. Was case referred to medica	I				26. Place of De	1 □Yes ath (Check only o		I L Tes	2 🗆 NO	-
†	is dir	To B	examiner? 1 ☐ Yes 2 🔀 No	Hospital: 1 ☐ In	patient 2 🗌	ER/Outpatie	ent 3 DOA Othe	er: 4 🗆 Nursing I	Home 5 ☐ Resi	dence 6	☑Other (Specif	N HOSPICE	
Division of Vital Records,	ding h. After funer	ation:	27. Manner of Death 1 Natural 5 Pendir 2 Accident investi	9 .	Injury , <i>Day, Year)</i>	28b. Time (Injury	Work		28d. Describe			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Divis	i i ite	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	pined 28e. Place o	f Injury - At ho g, etc. <i>(Specif</i>)		treet, factory, office		28f. Location (City or To	Street and wn, State)	Number or Rura	l Route Number,	
	To the Hospital or Al within 24 hours after of To the Funeral Direc completely filled in by	Medical	29a. Certifier 1 Certifyii (Check only one) 2 Medical	ng Physician: To the b Examiner: On the bas and manne	sis of examina	wledge, dea tion and/or i	th occurred at the tin nvestigation, in my o	ne, date and plac pinion, death occ	e, and due to the urred at the time,	cause(s) date and	and manner as s place, and due to	stated. the cause(s)	
	To the complete complete the co	Ž	29b. Signature and title of certific		X)	29c. License				signed (Month,		
				101	1)/	<u>ا</u>		4395	5	Aug	UST 28	,2008	
	3		30. Name and address of person DANIEUE DO. 31. Date filed (Month, Day, Year)	who completed cause	of death (Item	23a) (Type	Print) N CHARLE	ts 87, 8	UITE 26	99 B	ALTIMITÉ,	MD 21204	
	Sta Registr		31. Date filed (Month, Day, Year)	2008 33 Re	gistrar's Signa	auge /	rente						

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2008 **Physician** 5:20 РМ John Charles Fallon August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella Maris Baltimore Timonium If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Fenruary 19,1931 Birthplace (State or Foreign Country)
 Ohio 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1**X** M 2□ F Months Days 213-28-9700 **Director** Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinating the notified at 1 ☐ Yes 2 X No Funeral Director Maryland | Baltimore Timonium 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21093 United States 2300 Dulaney Valley Rd. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates:1953-55 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify þ Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) insurance insurance negotiator 18. Mother's Name (First, Middle, Maiden Surname) Maryland 17. Father's Name (First, Middle, Last) Be Ruth Helen Bishop George Lawrence Fallon မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Q. Fallon/wife Towson, MD 1803 Leadburn Rd. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory Aug. 29,2008 Baltimore, Maryland Mitchell-Wiedereld Funeral Home, Inc 21. Signature of Funeral Service Licensee Inc. Approximate Interval Between Onset and Death **Physician** /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner Hospital or Attending Physiclan: The law requires that the death certificate be execut Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ onknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 1 □Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | ■ 46 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manne Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred tural 5 Pending investigation 1 ☐ Yes 2 ☐ No after death 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier ifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 24 ho

To the Fune

completely f (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EDDIE NAKHUDA, M.D. 2300 DULANEY VALLEY ROAD TIMONIUM 21093 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2008 Registrar

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Baltimore, 5:20

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Records,

Vital

Division of

JOHN FALLON

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7008 FIELDS SEVON RB /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner MONTGOMER HOSPITAI SILVER SPRING ROSS | If Under 1 Year | If Under 24 Hrs. | B. Date of Birth (Month, Day, Year) | OS | OS | OS | Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) 5. Social Security Number 6. Sex 102M 2□F **Funeral** Director infant Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location the Maryland 10a. State 10b. County ns 23a or 28a-f show 1 Yes 2 No HYATTSVILL Director MI 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 2078 USA 690 PLACE Funerai 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? rithen "netural", or Items the Medical Examiner ma 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Baltimore, Maryland 21215-0036 Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Hygiene. INFANT INFAU M N A B Ith and Mental Hygier 27 Ie marked other the traumatic event, Ibs 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be CUARDONNA ROUGAND FIRLDS UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SS,MD. 20910 CROSS HOSPITAL If item 27 1500 FOREST GLEN RD HOLY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of F
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 5 X Other (Specify) in/state 4 Donation State and atomy aboard 655 W. Baltimore Street 21. Signature Funaral Tryice Licensee Nade, Director Baltimore, MD 21201 err 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Immediate Gause (Final disease or condition resulting in death) PIREMATURIT Physician EXTREME /Medical Due to (or as a consequence of) Examiner SEFSIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physicien and for use as the burial-transit Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf death 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. the a 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. à After this certificate has been sign funeral director, page 2 should be 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 Minpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA Certification; To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manger of Death Injury 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A
completely filled in by the fu 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0005715 2008 30. Name and address of person who compfeted cause of death (Item 23a) (Type, Print) DANN 1500 FOREST GLEN RD SS.MD. WALTON $\mathcal{D}\mathcal{K}$ 2. Registrar's Signature 31. Date filed (Month, Day, Year) AUG 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For Amend Item 25 State of Maryland / Department of Health and Mental Hygiene State of Maryland / Department of Health and Mental Hygiene Pegistraramend #8 Per FH G883 9/10/08 CHITCHE OF Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year James Grogan

4a. Facility Name (If not institution, give street and number) 0956 AM 2008 July /Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death Northwest Hospital RUNdallstown Bultimore CENTER 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign **Funeral** 10M 20F Months Days Hours 80 245-30-446 Usual Residence of Deceden Yrs Director the Maryland 10a State 10c. City, Town or Location 10b. County 10d. Inside City Limits r than "natural", or Items 23a or 28a-f shov the Medical Examiner must be notified at 1 TYes 2 No Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Walbros 30) Be Completed by Funeral Pages 1 and 2 should be filed within 72 hours after death nent of Health and Mental Hygiene.
ant: If Item 27 Is marked other than "natural", or Items 23 Lry or other traumatic event, the Medical Examiner must Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 pres 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry elmore Corporation Elementary/Secondary (0-12) College (1-4or 5+) 7 ver 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) brogan brus ဂ္ Tamle 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City, or Town, State, Zip Code) Department of Health al Important: If Item 27 Is any Injury or other trau 968 Williams-daughter en heights timore Mary 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 7/29/08 4 □ Donation 5 □ Other (Specify) Garrison 21. Signature of Funer Swice License 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. pproximate nterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardispulmonary /Medical Due to (or as a consequence of): Examiner ration Se in ni o'ly lift conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner death certificate be executed Multiple M

Due to (or as a consequence of): physician and s the burial-trans Myelono CERTIFICATIO P.O. Box 68760, Physician/Medical as the attending for use IF FEMALE 23c. If yes, outcome pf pregnancy 1 ☐Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown detached 9□Unknown n signed by th. 1 be detr Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ofiknown Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy 2 No 1□ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner?
1 X Yes 2 No director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: P 2 ER/Outpatient 3 □ DOA 1 Inpatient funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation Injury 2 ☐ Accident 1 ☐ Yes 2 ☐ No filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical To the and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0065425 JUly 19, 2008 30. Name and address of person who complete cause of death (item 23a) (Type, Print) HOSP. Northwest Center 5401 Old Court Rd Randallstown MD 21133

State Registrar 31. Date filed (Month, Day, Year)

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32. Registrar's Signature

			For State	State of Maryland		nt of Health and te of Death		2000	27844
6	Physicia	an	1. Decedent's Name (First, Middle, Last	(i) ((((((((((((((((((Ochinca	le or beating	2. Date of Dea	eg. No. th	3. Time of Death
	/Medic	al	Aaa Facility Name (If not institution, give	Grittin	4h Cih	, Town, or Location of Deat	Aug.	4c: County of Di	8 7.55 M
	Examin	er	Alice Manor	Nursing Ho	me F	Baltimore	2	N	TA .
Ę	Funeral Director		5. Social Security Number 6. S 213-20-4495	ex 7. Agg (In yrs. Ia		r 1 Year If Under 24 Hrs Days Hours Min		1909 V	irthplace (State or Foreign Country)
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Ē	%		23a. Pary Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final	plication wat caused the death.	. Do not enter the mo	de of dying, such as cardia	c or respiratory and	rest,	Approximate Interval Between Onset and Death
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2	s after al Dire ed in by	Certification:	4 Homicide determined	building, etc. (Specify,)	ry, onice	City or Tow		riciar ricula rambar,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical (29a. Certifier 11 Certifying Pt (Check only one) 2 Medical Exar	nysician: To the best of my knowniner: On the basis of examination and manner stated.	wledge, death occurre ion and/or investigation	d at the time, date and place n, in my opinion, death occ	e, and due to the curred at the time,	cause(s) and manne date and place, and	r as stated. due to the cause(s)
	within 7	Med	29b. Signature and title of certifier	O	2	9c. License number		29d. Date signed (M	onth, Day, Year)
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-	3		30. Name and address of person who	completed cause of death (Item A L 1 & 2 1	23a) (Type, Print)	utaw st. &	Baltin	ne M/	2/20/
200	Sta Registr		31. Date filed (Month, Day, Year)	2. Registrar's Signat	document of the state of the st				

			For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F r <i>tificate of I</i>			giene Reg. No. 0	08	278	345
			1. Decedent's Name (First, Middle, La	_				2. Date of Dea	Day	Year	3. Time o	f Death
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	Examin	er	4a. Facility Name (If not institution, gi				Location of Death			ly or Death ltimo	v.	
	Funeral	_		Sex 7. Age	e (In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da	h	9. Birthp	lace (State	or Fo reig n
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	and		Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or Lo	ecation				1	0d. Inside C	City Limits
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(O	should be filed within 72 hours after death with the Maryland of Mental Hyglene. marked other than "natural", or Items 23a or 28a-f show imatic event, the Madical Exerciper must be notified at	Funeral Director	11. Marital Status1 ☐ Never Married2 ☐ Married	12. Was Decedent B Armed Forces?	No I	Was Decedent of H		Rican, etc.)	В	lack, White,	etc.	
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Maryland	d d d	Be (17. Father's Name (First, Middle, Las	Ŋ		:	18. Mother's Nam	ne (First, Middle,	Maiden Surn	ame)		
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	attending properties		IF FEMALE:	23c. If yes, outcome	of pregnancy				23d.	Date of deliv	erv	
Box	death e atter d for u	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 \(\subseteq Yes \) 2 \(\subseteq No \)	1 ☐ Live birth 4 ☐ Pregnant a	2 ☐ Fetal death 3	□ Ectopic pregnand □ Other (specify) _	су			Month	Day	Year
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COL	w requir been s should	letec						24a. Was	 _	b. Were aut	psy finding	s available
Vital Records,	The lav te has age 2:	Completed						auto perfo 1 □ Yes	psy ormed? 2 No	prior to co death? 1 ∐Yes	mpletion of 2 □ No	cause of
ita	hyslclan; The Is his certificate ha I director, page 2	BeC	25. Was case referred to medical examiner?				26. Place of Dea				& pas	7.415
<u>~</u>	Physician: r this certific ral director, p	မ	1 ☐ Yes 2 XXIII		ent 2 ER/Outpatie	ent 3 L DOA		lome 5 ☐ Res		Other (Spec	M) Hos	OICE_
uc	ding Afte fune	ion:	27. Manner of Death 12 Natural 5 Pending investigati	28a. Date of Inju (Month, Da	ury 28b. Time ny, Year) Injury	Wo	rk?]Yes 2□No	28d. Describe	now injury occ	currea		
Division of	eat or:	Certification:		be 28e. Place of Ini	fury - At home, farm, s ic. (Specify)			28f. Location	Street and Nu wn, State)	mber or Rui	al Route Nu	ımber,
á	s afte	Cert										
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	Medical	29a. Certifier Check only one) Check only 2 Medical Ex	Physician: To the best aminer: On the basis of and manner st	of examination and/or	th occurred at the t nvestigation, in my	ime, date and place opinion, death occu	e, and due to the urred at the time	e cause(s) and , date and plac	I manner as ce, and due	stated. to the cause	e(s)
	To the vithin To the comple	Me	29b. Signature and title of certifier	N	2	29c. Licen	se number		29d. Date sig	ned (Month	Day, Year)	
	V		· CARIC	8011		- 01	587-	2	Lugar	+2	,20	268
1	2		30. Name and address of person wh	o completed cause of a	death (Item 23a) (Type	Print) NAÎN	Street	×	2113	6		
	Sta Regista		31. Date filed (Month, Day, Year) AUG 2 9	2008 32 Registr	rar's Signature	Print) Maria Maria	- 10					
	negist		E 0 000	- 1	e e							

08-06004	
George Griffith	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

eorge Gilliun		1-For State Of Maryland / Department of Health and Mental H	yglerie Reg.	200	18 2784
Physicia	ın/	Redistrar 1. Decedent's Name (First, Middle,Last)	2. Date of Death)av Year	3. Time of Death 1045 hrs
ledical Exami	ner	George Griffith 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death	August 6, 20	4c. County of Deat	
		221 South Broadway Street Baltimore			
Funeral Director		5. Social Security Number 6. Sex 1 X M 2 F 6. Sex 1 X M 2 F 6. Sex 1 X M 2 F 6. Sex 1 X M 2 F 6. Sex 1 X M 2 F 6. Sex 1 X Months Control of the control of t		F	rthplace (State or unk gn ountry)
any	}	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
<u> </u>	'n	MD Baltimore			1 Yes 2 No
Maryland r 28a-f sho ed at once.	Director	10e. Street and Number 10f. Zip Code	10g	. Citizen of What Cou	untry?
rith the 1.23a or notifie		221 South Broadway Street 21231 11. Marital Status unk 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Reports)	pecify Yes or No-	USA	rican Indian, Black,
leath w	Funeral	1 Never Married 2 Married Armed Forces? unk If Yes, specify Cuban, Mexican, Puerto		White, etc.	,,
after o	by F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2A No specify:			white
2 hours "natu	eted	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret		16b. Kind of Business	/Industry unk
036 ithin 7 me. r than	omple	unk unk			
215-0036 be filed within 7 ntal Hygiene. ked other than	ပိ	17. Father's Name (First, Middle, Last) unk 18. Mother's Name	e (First, Middle, Ma	aiden Surname)	unk
Mer Mer	To B	19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or			te, Zip Code)
MD and 2 sho m 27 is aumati		O.C.M.E. 111 Penn Street Balt			Town Chate
Baltimore, ME permit Pages I and 2 s Department of Health as Important: If item 27 injury or other traum		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - City of	or Town, State
Baltimore, permit. Pages I an Department of Her Important: If the		4 Donation 5 N Other Specify in State 21. Signature of Funeral Carries Licensee 22. Name and Address of Facility			
Balt permit Depart Impor injury		21. Signature of Funeral Project Licensee 22. Name and Address of Facility State Anatomy Boa Raltimore MD 21			e Street
Physician /Medical		23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac failure. List only one cause on each line.	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
xaminer		Immediate Cause (Final disease or condition resulting in death) a. Atherosclerotic Cardiovascular Disease Due to (or as a consequence of):			Death
- '		Sequentially list conditions, b			
	aminer	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated			
uted nd ransit	Щ	events resulting in death) Last Due to (or as a consequence of): d.			
760, cate be executed physician and the burial - transi	Medical	UNPENDED AMENDED			
8760, ifficate be ng physic is the buri	n/Me	IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	nancy	23d. Date of deliver	ery Day Year
Box 687(death certifica the attending pl	sician/	past 12 months? 4 Pregnant at time of death 5 Other (Specify)		1	9
O. Bo) It the deat I by the att	Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	pacco use contribute t	to the cause of death?
p.O.	d by	Congestive Heart Failure, Diabetes Mellitus, Emphysema	1 Yes	2 No 3 Pr	obably 4 🗸 Unknown
ords, w requir	Completed		24a. Was a autops perform	y prior to	autopsy findings available completion of cause of
tal Rec cian: The la certificate h	Com		1 Yes 2		Yes 2 No
'ital sician: is certif	Be	25. Was case referred to medical examiner? 4. More 20. Place of Death (Check examiner) 4. More 20. Place of Death (Check examiner) 5. Place of Death (Check examiner) 6. Place of Death (Check examiner) 6. Place of Death (Check examiner) 7. Place of Death (Check examiner) 8. Place of Death (Check		Residence 6 🗸 Oth	ner: Scene
ision of Vital Rec Attending Physician: The releath. retor: After this certificate by the funeral director, page	n: To	27. Manner of Death 28a. Date of Injury (Month Day Year) 28b. Time of Injury 28c. Injury at Work?		ow injury occurred	
sion ttendii death. rtor: /	atio	Pending Accident Investigation			
Division of Vital Records, ital or Attending Physician: The law requir nrs after death. ral Director: After this certificate has been similed in by the funeral director, page 2 should b	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Si or Town, Sta		Rural Route Number, City
Division of Vital Records, P.O. Box 68760, within 24 hours after death. To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.	Medical C	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, an which was a manner of the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	d due to the cause at the time, date a	e(s) and manner as st and place, and due to	ated. the cause(s)
5 7 8 5 8	Me	29b. Signature and title of certifier 29c. License number		29d. Date signed (M	
		Man Granel MD O.C.M.E.		August 21, 200	8
		30. Name and address of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
	ate	31. Date filed (Manufor Day, Year) 2008 Pegistrar's Signature			
Regis	Jar				

OCME

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Frederick Paul Hulvey Jr. 6:44 P. M August 27, 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Hospital Baltimore City 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/06/1930 9. Birthplace (State or Foreign Funerai Days Hours Min 1₩ 2□ F Maryland 212-24-4065 77Yrs Director Usual Residence of Decedent 10h County 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, If we Medical Examinar must be notified at Baltimore Maryland Baltimore 1XYes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 4401 Roland Avenue Apt. 308 21210 of America Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1₩Xes 2 □ No IYês, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 þ 1 ☐ Yes 2√ No Specify. Specify: white 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) self employed Travel Agent 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick Paul Hulvey Sr. Laura Peacock ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Peach/ friend 28 Old Dominion Court Catonsville, Maryland 21228 20b. Place of Disposition (Name of Evants Function) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State August 28, 4 ☐ Donation 5 ☐ Other (Specify) Chapel-Bel Air 2008 Forest Hill, Maryland 21. Signature of Juneral Service Licenses 22. Name and Address of Facility eaceful Alternatives Funeral & Cremation Ctr., P.A. reto 2325 York Road Timonium, Maryland 21093 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** OURMO(disease or condition resulting in death) /Medical D e to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed and -tran burial-1 Due to (or as a consequence of) Box 68760, physician a Physician/Medical attending p IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) signed by the a 1 be detached for P.0. 1 ☐Yes 2 ☐No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? of Vital Records, Completed by 1√ Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed page certificate 1 ☐Yes 2 ☐ No 1 ☐ Yes 2- No Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To After thi funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Division 1 Natural 2 Accident 5 ☐ Pending investigation iours after death.

neral Director: Af
filled in by the fur 1 □ Yes 2 □ No 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a

To the Funeral C

completely filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. To the within 2 To the I 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 30 GONACUM 31. Date filed_(Month, Day, Year) 32. Registrar's Signature AUG 2 9 2008 Registrar

			For State Registrar	State of Mar	yland		rtment of tificate of				ene 0 0 8	3 27848
	Dharatat		1. Decedent's Name (First, Middle,	Last)		_			2.	Date of Death		3. Time of Death
74	Physicia /Medic		William Heller He	edeman					A	UGUST	Day Ye	
	Examin		4a. Facility Name (If not institution,	· · · · · · · · · · · · · · · · · · ·			4b. City, Town,				4c. County of D	
			Saint Joseph						owson			ltimore
	Funeral Director		5. Social Security Number 214–12–2578	Sex 7. Age (in yrs. las 87	st birthday) Yrs.	If Under 1 Year Months Days		Min.	Date of Birth (Month, Day,	^{Year)} 25,1920	Birthplace (State or Foreign Couptry) Maryland
			Usual Residence of Decedent		07				D(ecember	27,1720	naryrand
	how		10a. State 10b. County			Town or Loc						10d. Inside City Limits
	e Ma	cto	Maryland Baltim	ore	Tin	noniun	1					1 ☐ Yes 2 X No
	or 28	Dire	10e. Street and Number				10f. Zip Code			10	g. Citizen of What	Country?
	ath w	ral	2525 Pot Spring	Rd.			2109	3			United	States
	er de	nne	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. V	Vas Decedent of Yes, specify Cul	Hispanic Or pan, Mexica	rigin? (Specif in, Puerto Ric	y Yes or No- can, etc.)	14. Race - A Black, W	merican Indian, hite, etc.
36	within 72 hours after death with the Maryland lene. than "natural", or items 23a or 28a-f show he Medical Expreiser roust be notified at	by Funeral Director	1 ☐ Never Married 2 🛣 Married 3 ☐ Widowed 4 ☐ Divorced	1 ∐Yes 2 X No If Yes, Give Year or Dates:		1	□Yes 2 X No	Specify	<i>r</i> :		Specify:	white
Ģ	tural	ed	15. Decedent's			16a Deced	ent's Usual Occu	nation		1	6b. Kind of Busine	
215	in 72 n "ne	Completed	(Specify only highest Elementary/Secondary (0-12)	rade completed)		(Give	kind of work done	during mos	st of working	1	OD. TAILO OF DOSINE	so/moustry
21,	d with giene grene	E O	Elementary/Secondary (0-12)	College (1-4or 5+)		€	executiv	e			manufa	cturing
Þ	othe vent,	BeC	17. Father's Name (First, Middle, La	,				18. Moth	er's Name (F	irst, Middle, M	aiden Surname)	<u> </u>
Baltimore, Maryland 21215-0036	Menta	To E	William Dorman G	ill Hedeman				Heni	rietta	Meanor	•	
lar	2 shc and is ma		19a. Informant's Name/Relationship								City or Town, Stat	: .'. '
رن دن	and lealth m 27 her to		Elizabeth Nowlin	Hedeman/wii			Pot Spr			imonium	<u> </u>	093
or o	ges 1 If Ite or of		20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3	☐ Removal from State	20b. Plac	ce of Dispos netery, crem	sition (Name of natory or other pla	ice)	Date	2	0c. Location - City	or Town, State
Ë	t. Pa rtmer rtant: njury		4 ☐ Donation 5 ☐ Other (Spe		Gree					,2008	Baltimor	e, Maryland
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the "Modeal Examinating in at be notified at once.		21. Signature of Fuperal Service Lic	ensee		M ₁	Name and Addr	wiede	feld F	uneral	Home In MD 2121	۶ .
			23a. P. Enter the disease, or co	mplications that caused th	e death.	Do not ente	er the mode of dy	ing, such as	s cardiac or re	espiratory arre	rid ZiZi st,	Approximate
	Physician		Immediate Cause (Final	ly one cause on each line.								Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a c			CLITE 1	N_CR	ONIC	CONGES	STIVE	DAYS
	Examiner		CANCEL CONTRACTOR CONTRACTOR	, HEART		,						
	D #	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c	conseque	nce of):						
ilk.	ecute and trans	ami	Cause (Disease or injury that initiated events	c. ISCHEMI	cc	ARDI	MYOPE	THY				YEARS
), oč	De ex cian g rurial-	ũ	resulting in death) Last	Due to (or as a c		,						
98760	ficate be executed physician and s the burial-transit	dical		d. ACUTE F	KENA	L FA	LURE					DAYS
	certifi iding se as		IF FEMALE:	23c. If yes, outcome of	prechanc	71/						1
Box	death certific attending p	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2[Fetal d	eath 3□	Ectopic pregnan	су			23d. Date of Month	delivery Day Year
P.O.	uires that the de	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9 Unknown	ille oi dea	5L	Other (specify)					•
σ.	that ned b	y P	Part II. Other significant conditions	contributing to death but r	not resulti	ng in the un	derlying cause gi	ven in Part	l.	23e. Did toba	acco use contribute	e to the cause of death?
rds	quires an sign	d by								1 ☐ Yes	s 2 ⊘ No 3 □	Probably 4 Unknown
ပ္စ	law requir as been si 2 should I	Completed							- 4	24a. Was an	24b. Were	autopsy findings available
æ	The lav ite has age 2 (E								autopsy perform	ed? prior	autopsy findings available to completion of cause of
ita	ian: rtifica tor, p	BeC	25. Was case referred to medical					26 Place	e of Death (C	1 ☐ Yes 2 Check only one		es 2□No
-	nysic nis ce direc		examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 Inpatient	2 🗆 EF	R/Outpatien	3 □ DOA Ot				nce 6 Other (5	Inecify)
0 0	ding Physician; The I n. After this certificate ha funeral director, page	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Y	2	8b. Time of Injury	28c. Inju	ırv at			v injury occurred	poony
Sio	eath. or: A the fu	äti	2 ☐ Accident investigat	on		,,		Yes 2□	lNo			
Division of Vital Records,	Il or Attend after death. Director: / d in by the f	Certification: To	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		- At home (Specify)	e, farm, stre	et, factory, office		28f.	Location (Stre City or Town,	eet and Number or State)	Rural Route Number,
	spital		29a. Certifier 12 Certifying	Physician: To the best of r	my knowie	edge, death	occurred at the	ime, date a	nd place, and	d due to the ca	use(s) and manne	r as stated.
	To the Hospital or Attending Physician; The law requires that the death certif within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	one)	aminer: On the basis of example and manner state	xaminatio	n and/or inv	estigation, in my	opinion, de	ath occurred	at the time, da	te and place, and	due to the cause(s)
	T with	Σ	29b. Signature and title of certifier				29c. Licen	se number		29	d. Date signed (M	onth, Day, Year)
			ebalk	P, TYY			10/2/12	2588	6		augus	28, 2008
	45		30. Name and address of person wh	o completed cause of deat	th (Item 2	3a) (Type, F	rint)		-		1	
	,		31. Date filed (Month, Day, Year)	Sa Phojetra	Signatur	OSLE	3 DRIVE	TOW	SOH,	MARYL	AND 212	714
	Stat Registra		AUG 2 9 2	32 Registrar's	Je Je	Ing	SE)		•			
			AUG Z G Z	JUU JAKELAN	Jest.	Jakres						

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Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" or items 23a or 28a-f show any lipury or other traumatic event, the Markenia Earth and the Landlined at ONCE.
2	Physician /Medical Examiner
Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit.

Funeral Director

		1 - State Registrar				C	ertificate of	Death	Re	g. No.	2008	210)47
Dhysisi		1. Decedent's Name (First,	Middle, Las	t)					2. Date of Death Month		Year	3. Time of [Death
Physicia /Medic		RICHA	ARD		IRI	FAN			August			5:24	РМ
Examin		4a. Facility Name (If not ins						r Location of Death			County of Death		
		Greater Ba						owson		Ва	ltimor		
uneral		5. Social Security Number	6. Se	x Sym 2□ F	7. Age (In yrs. I	last birthda Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,		9. Birth	nplace (State or untry)	
irector		infant Usual Residence of Decede		21		115.		1 08	08/20	/08		USA_	-Mary
MC #		10a. State 10b. C			10c. City	y, Town or	Location			10d. Inside City L			
f sho	тō	MD			D	ALTI	MODE					1. Yes	2 🗆 No
28a	Director	10e. Street and Number			D <i>I</i>	ALL I	10f, Zip Code		10	10g. Citizen of What Country?			
3a or		2947 Mile	es Av	enue			212	11		USA			
ms 2	Funeral	11. Marital Status		12. Was Dece	edent Ever in U.	S. 1	3. Was Decedent of I	Hispanic Origin? (Sp	ecify Yes or No-		4. Race - Amer	rican Indian,	
or ite		1 Never Married 2	Married	Armed Fo 1 ☐ Yes	2√∑ No	If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc.						, etc.	
E g	by	3 Widowed 4 Div	vorced	If Yes, Gi Year or D			1 ☐ Yes 2 ☐ No		known		Specify:	White	
nato Meni	Completed	15. De (Specify only	cedent's Edu	ucation de completed)			cedent's Usual Occupive kind of work done		ina 1	6b. Kin	d of Business/I	ndustry	
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lygie ner th		A	фa			N.	A				NA		
d otl	Be	17. Father's Name (First, M	liddle, Last)				unk	18. Mother's Name			,		
narke narke	မ								IER GARI				
raun raun		19a. Informant's Name/Rel Greater Bal			140.00		ailing Address (Street					ip Code)	
m 27			LIMOL	e med C			Ol N. Char					F Ctt-	
or or		20a. Method of Disposition 1 ☐ Burial 2 ☐ Çrem			Signe	emetery, c	sposition (Name of crematory or other pla	ce)	Jale 2	OC. LOC	cation - City or T	rown, State	
rtant njury		4 □ Donation 5 🖺 Ot	//		<i></i>								
Department of heathr and wenter riggener in persons the partment of heathr and wenter a sear show any injury or other traumatic event, the Modern Ever, the former or other traumatic event, the Modern Ever, the former of the position of once.		21. Signature of Euneral S RONA	d Sicens	Wade, 1	rector		State Anat			Balt	timore	Street	
		23a. Part 1. Enter the disea	or com	lications that of	raused the death	Do not	Baltimore,	MD 2120	1	ot		Approximate	
	shock, or heart failure. List only one cause on each line.											Interval Betw Onset and D	veen
/sician ledical		disease or condition resulting in death)	-	α,	REME		REMATE	IRITY					
aminer		,		Due to	(or as a consequ	uence of):							
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		b Due to	(or as a consequ	uence of):					-		
unsit	min	cause. Enter Underlying Cause (Disease or injury that initiated events	<		,								
n and ial-tra	Examiner	resulting in death) Last		c Due to	(or as a consequ	uence of):							
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endir		IF FEMALE: 23b. Was decedent pregna	nt	23c. If yes, out	tcome of pregna	ncy	0.05			23d. Date of delivery			
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ertific sctor,	Be	25. Was case referred to me examiner?	-					26. Place of Deat	h (Check only one	9)			
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tor: /	cati	E	nvestigation Could not be]Yes 2□No					
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filled		29a. Certifier 1√ Ce	etificine Dh	raining. To the	hoat of my loon					/ >		-1-1-1	
Fun	Medical		dical Exam	iner: On the b	asis of examina ner stated.	tion and/o	eath occurred at the t r investigation, in my	ime, date and place, opinion, death occur	red at the time, da	ause(s)	and manner as place, and due	to the cause(s)	
The part of the pa							d. Date	e signed (Month	n, Day, Year)				
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Sta	te	31. Date filed (Month, Day,	Year)	₩ 2. F	legistrar's Signa	ture	DAR D	-U- OIK	101	1 1	1,00000	71.0	
Registra		AUG 2	9 200	3 Klein	kin S.	A							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 8 1 - For State Registrar Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 4b. City, Town, or Location of Death

Buttiwore

If Under 1 Year If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year)

Months Days Hours Min. | 8-17-08 5:50 PM **Physician** /Medical 4c. County of Death Examiner Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 152 M 2 ☐ F 0 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits daath with the Marylend 10c. City, Town or Location 10a. Ştate 10b. County is 1 and 2 should be filad within 72 hours eftar daath with tha Marylen of Haalth and Mantal Hygiena. It has the 23a or 28a-1 show teams 22a or 28a-1 show other treumstic event, the Macdal Examiner must be notified at MARTINSBURG 1 Tes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 25405 STREET NORTH Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status e filad within 72 hours eftar of Hygiena. Il Hygiena. other than "neturel", or Itel 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK Baltimore, Maryland 21215-0036 Specify. δ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) INFaN + Elementary/Secondary (0-12) College (1-4or 5+) INFANT 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 KATINA JONE UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) TO BIRD STREET, NORTH MARTINS BURG, WV 25465 MOTHER KATINA JONES 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pagas 1
Dapartmant of Hz
Important: If iten
eny injury or oth 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Cathedral Cem. * 4 ☐ Donation 5 ☐ Other (Specify) 10-30-08 Baltimore Fun exal Home 22. Name and Address of Facility Bradley - ASLLON 21. Signature of Funeral Service Licenses SDRING W Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest; shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician /Medical Examiner hanato phoric Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attanding physician end for usa as tha burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) ed by tha a 9 Unknown 9 Unknown bean signed be should be date 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an has 22 No 1 ☐ Yes diractor, 8 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ို this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide within 24 hours a To the Funeral C complataly fillad 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Ildore Wonodi, M.D. D0061048 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Defautment of Bediatrics, Mercy Medical Center, Bultimore, MD 21202 32. Registrar's Signature 31. Date filed (Month, Day, Year) State AUG 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** ackson am 2008 Dara /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b City, Town, or Location of Death Examiner SAMORE Grenera If Under 1 Year | If Under 24 Hrs.
Months | Days | Hours | Min Birthplace (State or Foreign Country)
 D 7. Age (In yrs. last birthday 5. Social Security Number 217-40-Date of Birth (Month, Day, **Funeral** Year) -40-361 6 08 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages I and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic e-ent, the Medical Examiner must be notified at any Injury or other traumatic e-ent, the Medical Examiner must be notified at any Once. 1 Nes 2 No Director imore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Id trederic 5 21229 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ∏Yes 21 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐Yes 2 No Specify Specify: Completed by Black 3 Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be mes ည CA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Madison Balto, MD 21217 AVR erald 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Crownsville rownsville 09-03-08 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility JAMES A. MORTON & SONS F.H., INC 21. Signature of Funeral Service Licensee 1701 LAURENS ST., BALTO., MD 21217 ames Q. 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atheroselerotic **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner ber ten sici Gequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner e o (or as a consequence of) Hospital or Attending Physician; The law requires that the death certificate be executed burial-transi and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, ned by the attending physician detached for use as the buria Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown sate has been signed by page 2 should be detacl 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate 2 No 1 ☐ Yes completely filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Date of Injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? within 24 hours after death.

To the Funeral Director: After 1 Matural 5 ☐ Pending investigation 1 ☐Yes 2 ☐No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number ٥ gream 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501 Dolphin Street Baltimore, Md. 21217

State Registrar

31. Date filed (Month, Day, Year) 2008 AUG 29

32. Registrar's Signature

08-06556 Floyd Jones

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Physician/ dical Examine Funeral Director	er		NEC ID				0.0			
Funeral	4		NES, JR.			10.	2. Date of Death Month August 27,	Day Y 2008		ime of Death U 620 hrs
		a. Facility Name (if not institution, give s Johns Hopkins Hospital	treet and number)		. City, Town, or Baltimore	Location of Dea	th	4c. Count	y of Death	
	L		7. Age (In yrs. last	t birthday) Yrs.	Months Days				9. Birthpla Country Mary	ce (State or Foreign) land
v any	1	Usual Residence of Decedent Oa. State 10b. County	10c. City, To	own or Location					- 1	. Inside City Limits
the Maryland to 28a-f show iffed at once.		MD N/A Oe. Street and Number		BALTI	MORE		10	g. Citizen of	What Country?	Yes 2 No
th the Maryland 23a or 28a-f sho notified at once.		1536 LESTER Mo			21205			USA		
er death wi		1 Never Married 2 X Married	12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No Yes, Give Year	If Yes		n, Mexican, Puer	Specify Yes or No- to Rican, etc.)	WI	nce - American hite, etc. y: blac	
2 hours aft "natural" Examine		15. Decedent's Education (Specify only Elementary/Secondary (0-12)	chighest grade completed) College (1-4 or 5+)			tion (Give kind o . DO NOT use re		16b. Kind of	Business/Indus	stry
5-0036 lide within 72 hour lide within 72 hour lygiene. Lother than "natu the Medical Exar Completed			1 yr	LAB	ORER	,			NSTRUC'	TION
21215-0036 build be filed within 73 Mental Hygiene. marked other than ic event, the Medical TO Be Comple	֓֞֞֞֜֞֜֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֡֓֓֓֓֓֡֓֡֓֡֓֡	7. Father's Name (First, Middle, Last) FLOYD JONES	SR.				ne (First, Middle, N SINIA LE			
MD 21 d 2 should lth and Me in 27 is ma iumatic ev	2 1	9a. Informant's Name/Relationship (Type EVELYNA NUTTER					Rural Route Num Baltimo			
Baltimore, MD 21215-003 permit. Pages I and 2 should be filed within Department of Health and Mental Hygiene. Important: If iten 27 is marked other it injury or other traumatic event, the Med To Be Comm		20a. Method of Disposition 1 Burial 2 X Cremation 3 4 Donaton 5 Other Specify:		ace of Dispositi ematory or othe EEN MO			G. 29,2		on - City or Tow	n, State
Balt permit. Departin Import injury	2	21. S re of Funeral Service License	Thurs	22 Na CA 1 4	me and Address	S of Facility S CRU	GGS FUN	IERAL	HOME	1213_
Physician /Medical Examiner		23a. Part I. Enter the disease, or complicing failure. List only one cause on each ammediate Cause (Final disease a. H		Do not enter the	mode of dying,	such as cardiad	or respiratory arre	est, shock, or	heart A	pproximate Intervi Between Onset an Death
executed an and al-transit	Examine	cause. Enter Underlying Cause	ue to (or as a consequence of):			W				
	5 J ∪	UNPENDED F FEMALE:	AMENDED 23c. If yes, outcome of pregna	ancy				23d. Date	e of delivery	
Box 68760, e death certificate be the attending physic ed for use as the bur hysician/Mec	Sician	3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	1 Live birth 4 Pregnant at time of dea	+h =	er (Specify)	Ectopic preg	nancy	Month	n Day	Year
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Vital Rec ysician: The I his certificate director, page		25. Was case referred to medical examiner?	snital:			e of Death (Che				
ing Phys After this funeral di	112	1 ✓ Yes 2 No 27. Manner of Death	28a Date of Injury	ER/Outpatient 28b. Time of Inj		ury at Work?	28d. Describe			
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DIVISION O spital or Attending tours after death. Increal Director: After filled in by the fune		3 Suicide 6 Could not be determined	28e. Place of Injury - At hor (Specify) Local Street		, ractory, office	building, etc.	or Town, S E. North Aver			Route Number, Cit imore, MD
DIVIS To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b Medical Certific		one) 2 Medical Examiner:	n: To the best of my knowledge On the basis of examination and and manner stated.							ause(s)
F S F S B	M 2	29b. Signature and title of certifier			29c. Licens	se number .M.E.			igned (Month, 28, 2008	Day, Year)
B	3	30. Name and address of person who co Ana Rubio MD. Assistant			reet, Baltim	ore, MD 212	01			
	te 3	31. Date filed (Month, Day, Year)	32. egistrar's Signatur					<u> </u>		

dent's Name (First, Middle, Last)		2. Date of Death	3. Time of Death
te gistrar	State of Maryland / Department of Health and I Certificate of Death	Mental Hygiene 2008	27853

Physician	
/Medical	
Examiner	

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exprinter mest be notified at once.

Baltimore, Maryland 21215-0036 Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Sta Registra

•	For State Registrar	Otate of Mic	ii yiaiia 7		tificate of E		u ivici		eg. No.	2008	2/853
_	1. Decedent's Name (First, Middle, La	st)					2.	Date of Deat	h Day	Year	3. Time of Death
al		Cecile W	ilson	Kerr	<u> </u>		A	ugust	25,	2008	1:32 A M
er	4a. Facility Name (If not institution, give				4b. City, Town, or	Location of De	eath			County of Deat	th
	14641 Viburnum D 5. Social Security Number 6.5		e (In yrs. last i	hirthday	Dayton If Under 1 Year	If Under 24 H	irs. I a	Date of Birth		oward	thplace (State or Foreign
		1 □ M 2 🔀 F	91	Yrs.	Months Days		lin.	Date of Birth (Month, Day,	Year)	Co	th Dakota
	Usual Residence of Decedent		<u> </u>				15	ebr 10	,	910 50u	CII DAKOLA
_	10a. State 10b. County		10c. City, To	wn or Loc	ation						10d. Inside City Limits
cto	MD Howard		Dayto	n							1 ⊠Yes 2 □ No
Ö	10e. Street and Number				10f. Zip Code					zen of What Co	ountry?
<u>ra</u>	14641 Viburnum D	rive		I	21036				U.S.		
Ĕ.	11. Marital Status	as Decedent of Hi Yes, specify Cubar	spanic Origin? n, Mexican, Pu	(Specify Lerto Ric	y Yes or No- an, etc.)	1	 Race - Ame Black, White 				
by	1 ☐ Never Married 2 🖾 Married 1 ☐ Yes 2 🛣 No If Yes, Give 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates:									Specify: TATH	nite
Completed by Funeral Director	15. Decedent's E	ducation	16	6a. Decede	ent's Usual Occupa	ation			16b. Kin	nd of Business/	
nple	Elementary/Secondary (0-12) College (1-4or 5+)								ited St		
ပ္ပ		1		Clain	ns Proces					vernmen	t
To Be	17. Father's Name (First, Middle, Last	")				18. Mother's N				Surname)	
٩	Earl Wilson							es Dun			
	19a. Informant's Name/Relationship				Address (Street a						
	Jacqueline K. Da 20a. Method of Disposition	rmody /dau			ll Viburn ition (Name of		ve, Date		<u></u>	aryLand cation - City or	
	1 ☐ Burial 2 🖾 Cremation 3 🛭				ition (Name of atory or other place	í	26			•	
	4 ☐ Donation 5 ☐ Other (Speci 21. Signature of Funeral Service Lice		W. Al	22.	1 Cremato Name and Addres	s of Facility				ton, Ma	aryland
	Whill Co	V//	M00773	Do	onaldson 3 Talbot	Funeral	l Ho Lau	me, P. rel. M	A. arvl	land 20	707-4389
	23a. Part 1. Enter the disease, or con	pplications that caused	the death. D	o not ente	r the mode of dying	g, such as care	diac or re	espiratory arr	est,		Approximate Interval Between
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Colon Cancer									Onset and Death		
resulting in death) a. COTOTI CATICET Due to (or as a consequence of):											
_	Sequentially list conditions,	b. Coronar			sease						
nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as									
xar	that initiated events resulting in death) Last	c									
ca 		d									
Completed by Physician/Medical Examiner	15 551111 5										
an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 Live birth			Ectopic pregnancy	,			2	23d. Date of de	•
Sici	in the past 12 months? 1 ☐ Yes 2 🖾 No	4 ☐ Pregnant a 9 ☐ Unknown	t time of death	h 5□	Other (specify)					Month	Day Year
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ပ္တို	25. Was case referred to medical	T				OC Disease f	Dooth (1 □Yes	2 X No		s 2 No
o Be	examiner? 1 ☐ Yes 2 ☐ No	Hospital:	ent 2 ER/	/Outpatient	3 □ DOA Othe	26. Place of I				Other (Spe	acifu)
Ë	27. Manner of Death	28a. Date of Inju (Month, Da	ry 281	b. Time of	28c. Injury Work			d. Describe ho			. Sily/
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Ĕ	3 ☐ Suicide 6 ☐ Could not to determined	20e. Place of inte	ury - At home, c. (Specify)	, farm, stre	et, factory, office		28f.	Location (St City or Town	treet and n, State)	d Number or R	ural Route Number,
Medical Certification: To	200 Cortifier	hueleles T	-6	days 1 1				4.4			
dica	29a. Certifier 1 ✓ Certifying P (Check only 2 ☐ Medical Exa	hysician: To the best miner: On the basis o and manner sta	f examination	age, death and/or inv	estigation, in my o	ne, date and pi pinion, death o	occurred	at the time, d	ause(s) late and	and manner a place, and du	e to the cause(s)
Me	29b. Signature angutitle of certifier	and mariner ste	<u> </u>		29c. License	number		2	9d. Date	e signed (Mon	th, Day, Year)
	I Athi Nad	Le Hu	1		MO	6065	5		A	ug. 2	6, 2008
	30. Name and address of person who	completed cause of d	eath (Item 23	a) (Type, F		- 03				J	1
	Adrian Hurley	, M.D 10	0810 Cc	onnec	ticut Ave	. Kens	ingt	on, Ma	ryl	and	
e	31. Date filed (Month, Pay, Year) AUG 2 9	2008 32 Registr	ar's Signatura	Con	sell)				_		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 9:05AM AUGUST 2008 /Medical 4a. Facility Name (If not institution, give street and number)
GOOD SAMARITAN HOSP 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 X F Months Days Hours 220-14-4025 Director May 5, 1912 Maryland Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or Items 23a or 28a-f show other traumatic event, the Medical Examinar in ust be notified at Funeral Director 1 Yes 2 No MD altimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 212 hristopher Hvenue nited 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No Specify Completed by white 3 X Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ဂ္ antz 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Stanley Lanocha-2818 Christopher MDZ1214 altimore Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Pages
Department of
Important: If it
any Injury or o 1 XBurial 2 □ Cremation 3 □ Removal from State 4 Donation 5 DOther (Specify) kwood Cemetery 08 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FuneralC 8800 Wacu Ro 21234 Harford 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner INFECTION if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed the burial-transi and Due to (or as a consequence of) P.O. Box 68760, physician Physician/Medical for use 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) ed by the 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ No 3 Probably 4 Unknown 1 ☐ Yes Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed' this certificate 1 □ Yes 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 2 V Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manuer of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury After t 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number D 0066369 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp completed cause of death (Item 23a) (Type, Print) BLVD BALTIMORE 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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		•	State Registrar			Certificate of L	Death	Re	eg. No.2008	27855
7	Physici	an	1. Decedent's Name (First, Middle, Last)				1	Date of Deatl Month		3. Time of Death
	/Medic		Charles D. L					luguet	27 2008	1:00 A M
	Examin	er	4a. Facility Name (If not institution, give	,			Location of Death	,	4c. County of Deatl	h
		1	Keswick Multi-Ca 5. Social Security Number 6. Security Number 6. Security Number 16.		(In yrs. last bi		ore City	9 Date of Birth	O Died	poles (Chata a Familia
t	Funeral Director		302-22-0261	M 2□F	79	Monthe Dave	Hours Min.	8. Date of Birth Month, Day, 12/05/	Year) 1928 Laker	hplace (State or Foreign untry) WOOd, Ohio
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location				10d. Inside City Limits
	f sho	ō	Maryland Baltim			imore				Yes 2□No
	with the P a or 28a- be notiff	Director	10e. Street and Number 411 Wingate Roa	٦		10f. Zip Code 2121	0	1	og. Citizen of What Co United Stat	
	sath is 23; must	eral		12. Was Decedent Ev	vor in LLC				of America 14. Race - Amer	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Importants: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Married 3 □ Widowed 4 □ Divorced	Armed Forces? ↑ Types 2 No If Yes, Give Year or Dates:		13. Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes ∑∑No	Specify:	Rican, etc.)	Black, White	e, etc.
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and	be fil ntal H ed otl	Be	17. Father's Name (First, Middle, Last) Charles D.	Laidlaw Jr	•		18. Mother's Name		Maiden Surname)	
ž	hould d Mei narke natic	٩	19a. Informant's Name/Relationship (Ty			Mailing Address (Ctrosts		Bennett	City Town Ctots	7-0-1-1
<u>≅</u>	d 2 sl th an 7 is r traur		Patricia Laidlaw/			o. Mailing Address <i>(Street a</i> 11 Wingate R				
بن	1 an Heal tem 2		20a. Method of Disposition	-Forme					20c. Location - City or	
õ	ages ant of t: if it		N Burial 2 ☐ Cremation 3 ☐ F	emoval from State		of Disposition (Name of ery, crematory or other place Olumbia	e) August	t 29,		
Baltimore,	artme ortani Injury	-	4 □ Donation 5 □ Other (Specify) 21. Signature Fureral Service License	2	Mem	orial Park	2008 ss of Facility	8	Clarksvill	le, Maryland
Ba	Department and and and and and and and and and and		Met to K		<u>/</u>	22. Name and Address Peaceful Al 2325 Yo	ternatives	Funera	al &Cremati	lon Ctr.,P.F
	Physician /Medical Examiner		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	cations that caused to be cause on each line End-SHe Due to (or as a	age Pa	rpinson'n	g, odon do odroido o	respiratory arre	est,	Approximate Interval Between Onset and Death
68760, N	The law requires that the death certificate be executed the has been signed by the attending physician and sage 2 should be detached for use as the buriat-transit	Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a						
. Box	at the death certificate I by the attending physic tached for use as the t		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome p 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal deat	h 3⊟Ectopic pregnancy 5⊟ Other (specify) _			23d. Date of del Month	ivery Day Year
σ,	res that igned b	Y P	Part II. Other significant conditions con		not resulting	in the underlying cause give	en in Part I.	23e. Did tob	pacco use contribute to	the cause of death?
rds	w require been sig should b	a pa	Bullous Remy	higued				1 □ Y€	es 2⊠No 3⊟Pr	obably 4 Unknown
Vital Records, P.O	sician: The law re certificate has bee rector, page 2 sho	Completed by Physician		9				24a. Was an autops perform	n 24b. Were au y prior to death? 2 No 1 ☐ Yes	topsy findings available completion of cause of 2 ☐ No
Vita	sician: Th certificate ector, pag	Be	25. Was case referred to medical examiner?	lospital:		l out	26. Place of Death		e)	
ō	Phys this rat dir	2	1 Yes 2 No	1 Inpatien		utpatient 3 DOA Other	4 Mursing Hon		ence 6 Other (Spec	cify)
Division or	tending eath. tor: After the funer	cation	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	28a. Date of Injury (Month, Day		Injury Worl M 1 □	yat ⟨? Yes 2 □ No	Describe no	ow injury occurred	
Divi	tal or Atres after drai Directed in by	Certification:	4 ☐ Homicide determined	28e. Place of injur building, etc.	y - At home, fa (Specify)	arm, street, factory, office	2	8f. Location (St. City or Town	reet and Number or Ru n, State)	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	Medical	29a. Certifier 1 Certifying Physical (Check only one) 1 Medical Exami	sician: To the best of ner: On the basis of and manner stat	examination a	e, death occurred at the tir nd/or investigation, in my o	ne, date and place, a pinion, death occurre	and due to the ca ed at the time, d	ause(s) and manner as ate and place, and due	s stated. e to the cause(s)
	To the within Comp.	M	29b. Signature and title of certifier	One are	2 MD	29c. Licenso	e number	/	9d. Date signed (Mont.) Wyust 27,	
	541		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a)					W
	J		113056506 1007/2	-to1-1 100	VV -/	10 -11201	2.7 - 1 18/11		11-0-11	

State Registrar

31. Date filed (Month, Day, Year)
AUG 2 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August Howard E. Little 2008 1223p ^M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Harford Upper Cheaseake Medical Center Belair If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July12,1945 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 212-44-9279 63 MD Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits MD Baltimore Hydes 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 3102 Harford Road 21082 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐Yes 2 ☑No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Coordinator GM 11th 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Howard Little Ann Walker 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen S. Little 3102 HArford Road Hydes MD 21082 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 2000 Baltimore MD Bayview Crematory 251 4 ☐ Donatiop—5 ☐ Other (Specify) eral Service 21. Signature of Fall 22. Name and Address of Facility 300 Mace Ave. Balto. Connelly Funeral Home of Essex 21221 23a. Part f. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocord disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, Ite Modical Exemiter must be notified at

nd Mental Hygiene. marked other than

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/Medical

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Certification: To

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29a. Certifier

(Check only one)

29b. Signature and title of centile

burial-tran ass for use director, page 2 should Hospital or Attending Physician: The law 24 hours after death. has after death Director: filled in by the

			1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknow							
			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 □ No						
	Was case referred to medical examiner?	26. Place of Death (Check only one)								
	1 ≥ Yes 2 □ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)								
2	Manner of Death Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month, Day, Year) Injury Work? M 1 ☐ Yes 2 ☐ No	d. Describe how injury	occurred						
	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	if. Location (Street and City or Town, State)	Number or Rural Route Number,						

certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar

of person who completed cause of death (Item 23a) (Type, Print) 30. Name and add 31. Date filed (Month, Day,

Year)

pper chesapoake Dr. Bel 4'c mo 32 Registrar's Signature

00036487

29d. Date signed (Month, Day, Year)

To the Hospital or within 24 hours at To the Funeral D

			State of Maryland / Dep	partment of Health and Nertificate of Death		ene 008	27857				
	- E.		1. Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death				
	Physici /Medi		MARGARET P. LENHAM		AUGUST	28, 2008	4:55 A. ^M				
	Examir		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Dea	th				
7			GILCHRIST CENTER	TOWSON If Under 1 Year If Under 24 Hrs.	0.001(0.11	BALTIMO					
	Funeral Director		5. Social Security Number 125-05-6963 Usual Residence of Decedent 6. Sex 1 □ M 2 ☒ F 7. Age (In yrs. last birthda) Yrs.	/) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day, 9/27/191	Year) Co	thplace (State or Foreign ountry) NSYLVANIA				
	land ow		10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits				
	be filed within 72 hours after death with the Maryland that Hyglene. ed other than "natural", or items 23a or 28a-f show event, the Medical Enarther must be notified at	żo	MD BALTIMORE PA	ARKVILLE			1 ∐Yes 2∭X No				
		Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Co	ountry?				
			9208 SMITH AVENUE	21234		USA					
21215-0036		by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 Wolds of the Free Free Free Free Free Free Free Fr	. Was Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ▼No Specify:	ecify Yes or No- Rican, etc.)	14. Race - Ame Black, Whit					
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	ges 1 and 2 it of Health a if Item 27 is or other tra		20a Method of Disposition 20b Place of Disp	osition (Name of	POLIS, MI Date 2	2 1401 0c. Location - City or	Town, State				
Baltimore,	00		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	VALLEY MEM. 9/2/2	2008	COCKEYSVIL	re MD				
ij	permit. Page Department Important: I any Injury o		21. Signature of Funeral Service/Licensee GARDI	JNS							
ñ	any per			3521 LOCH RAVEN BL			HOME, P.A. 1286				
	Physician /Medical Examiner	. 71	23a. 11. Enter the disease, or implications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List buty one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Die to (or as a or induced of the conditions) Sequentially list conditions b. Approximate Interval Between Onset and Death Day 5 Sequentially list conditions								
68760,	es that the death certificate be igned by the attending physicis be detached for use as the bur	edical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):				5475				
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of Vital Records,	i c an: The law requ ce tificate has been ector, page 2 shouk	Completed	Chronic Renal Insupplie	prior to eqt?	utopsy findings available completion of cause of						
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É	I or Attending after death. Director: After d in by the funer	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)								
	To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	29a. Certifier (Check only one) 1. Certifying Physician: To the best of my knowledge, deal control on the basis of examination and/or and manner stated.	investigation, in my opinion, death occur	red at the time, da	ite and place, and du	e to the cause(s)				
	with Con	2	29b. Signature and title of certifier	29c. License number	29	ld. Date signed (Mon.	th, Day, Year)				
	~			n D64395	14	-ugust 2	-8,208				
1	1		30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	c 1 -	2 0 11					
2	0 Sta Registr	_	Danie (Ce. Oberman m.) 656 31. Date filed (Month, Day, Year) 32. Registrar's Signature AUG 2 9 2008	D64395 Print) Ni Charles St	·) uitla	LOG Balti	more, and 21284				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend Item 8 per fh 8883 9-3-08 vt
State of Maryland / Department of Health and Mental Hygiene
1- State Amend 19b, per FH G882 8/29/08 TT Certificate of Death

Reg. No. 2008 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Day Year **Physician** Catherine Lewis 3:57PM 08 26 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Pikesville Baltimbre Walnut If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Monta, Day, Year) **Funeral** 216.30.9191 Months Days Min. 1 □ M 2 🔭 F Hours MD Director DI 1933 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f shov Examiner must be notified at Baltimore MD Pikesville 1 ☐ Yes 2 X No Completed by Funeral Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21208 Avenue USA 7119 Walnut 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐Yes 2 XNo Specify: 3 Widowed 4 ☐ Divorced event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Baltimore County Elementary/Secondary (0-12) College (1-4or 5+) Cook Schools 12th arade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Shacklett Claude Marie Howard traumatic ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

7119 Wanut Avenue Britesville MD 21208 19a. Informant's Name/Relationship (Type. Print) Denise C. Wali Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Pages 1
Department of F
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any Injury or ot Burial 2 Cremation 3 Removal from State 09 03 08 Dyvings Milk, MD Garrison Forest 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Vaughn C. Greene Funeral Sucs N au 8728 Liberty Road Rundallstonn MD 21133 23a. Part 1. Ent. th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bladde **Physician** cancer with rina /Medical Due to (or as a conseque metastasin Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Certification: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): i or Attending Physician: The law requires that the death certificate be executed after death.

Director: After this certificate has been signed by the attending physician and After this certificate has been signed by the attending physician and tuneral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗆 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes ♣ ♣ No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 \sum Nursing Home 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 5 Desidence 6 ☐ Other (Specify) 27. Manner of Death
Natural
Z Accident 28a. Date of Injury (Month, Day, Year) 28h Time of 28d. Describe how injury occurred 28c. Injury at Work? Injury 5 Pending investigation M 1 □Yes 2 □ No the 1 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 4 Homicide e Hospital of 24 hours af Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier cal To the within 2 Medi and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD EUD C completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who Sinte 101 crossroads awaro lahouron 20 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 24a,25,26,27,28a,30 per dr., g882,08/29/08dhb rar Certificate of Death Reg. No. 1 - For A State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 22 **Physician** SHEILAH MICEL 07.40 PM August 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE n/a HARBOR HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Y 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Year) Min Months Days Hours California 1 □ M 2 🗹 F Director 217-62-6733 Usual Residence of Decedent should be filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 ☐ Yes 2 No Director Baltimore Essex Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21221 584 Hopkins Landing Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) nd Mental Hygiene. marked other than Elementary/Secondary (0-12) College (1-4or 5+) Furniture 12 Store Manager 18. Mother's Name (First, Middle, Maiden Surname) Be (17. Father's Name (First, Middle, Last) Health and Mental em 27 is marked o Edna Finnev David Reath ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2908 Berwick Avenue Baltimore Maryland 21234 Cheryl D. Reath (Sister) permit. Pages 1 an Department of Heal Important: If item 2 any Injury or other Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【 Cremation 3 ☐ Removal from State Hilltop Service Corp. 8/26/2008 Towson Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21204 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Md. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final ASPIRATION PNEUMONIA **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner UNG CARCINOMA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner requires that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical the as attending IF FEMALE asn 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? 1 ☐Yes 2 ☐No Month Day Year 5 Other (specify) P.0. the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 ☐ Yes 2 No 3 Probably 4 Unknown page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No The certificate Vital 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of this funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred After 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death.

Funeral Director: A 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 1 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier (Check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

To the within 2

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State Registrar 29b. Signature and title of certifier

and manner stated

eronica RS Fyrandes

29c. License number

RES_ 0000

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2. Date of Death

3. Time of Death August 27 Day 2009 Year C . OO . .

1. Decedent's Name (First, Middle, Last) **Physician** /Medica Examine

Funeral

Director permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Menfal Hygiene.

Department of Health and Menfal Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy highry or other traumatic event. It is Mariful Examination and once.

Baltimore, Maryland 21215-0036

Physician /Medical **Examiner**

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, within 24 hours after death.

To tha Funeral Director: A completely filled in by the fu

an al	Janice Berman Manna						August 27^{Day} 2008^{Year} 6:00 pm M					
er	4a. Facility Name (If no	a. Facility Name (If not institution, give street and number)					4b. City, Town, or Location of Death 4c. County of Death					
ľ	5. Social Security Num 217-64-112	8 1		7. Age (In yi	s. last birthda 6 Yrs.	Fallsto y) If Under 1 Year Months Days	If Under 24 Hours	Hrs. 8. Date of Bi Min. (Month, Da August 20	rth a <i>y, Year)</i>		County hplace (State or Foreign ountry) MD	
	Usual Residence of De	ocedent 0b. County		100	City, Town or	l anation					104 Incide Oile Links	
'n	MD	Harfo	rd	100.1	Falls						10d. Inside City Limits 1 ☐ Yes 2X No	
ect	10e. Street and Number					10f. Zip Code	<u> </u>		10- 0	i 186 O-		
ă										izen of What Co	ountry?	
era	2217 Hampshire Drive 11. Marital Status 12. Was Decedent Ever in U.S					21047 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Ra					nican Indian,	
Fun	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No										e, etc.	
by	If Yes, Give 3 ☐ Widowed 4 ☐ Divorced Year or Dates:					1 ☐ Yes 2 📉 No	Specify: Wh	ite				
Completed by Funeral Director		. Decedent's Ed			16a. Dec	cedent's Usual Occu ve kind of work done	pation	f working	16b. K	ind of Business	Industry	
npie	Elementary/Seconda		College (life	. DO NOT use retire	d)					
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Be	Joseph Be							s Name <i>(First, Middle</i> na Pohler	, Maiden	Sumame)		
T _o	19a. Informant's Name		Tuno Orinth		10h Ma	::::::::::::::::::::::::::::::::::::::			0.1	O-1-	7. 0. 4.1	
	Ralph P. M		ypa, <i>Frant)</i> Husband	1)				or Rural Rogte Numb				
	20a. Method of Disposi		iusballu	<u> </u>	Place of Dis	position (Name of		ive Fallst		ocation - City or		
	1 ☐ Burial 2 💥 0					rematory or other pla	· .	20 2000				
	21. Signature of Funer			De		Crematory 22. Name and Address		-29-2008		ltimore,	, MD ne of Bel Air	
	Bui	a.W	elle	_	6	10 W. Mac	Phail l	Road Rel A	rune	mon lare Marvlar	d 21014	
	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):								riar y rai	Approximate Interval Between Onset and Death		
ician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last b. Due to (or as a consequence of). c. Due to (or as a consequence of): d.											
S	9 Unknown					death 3 Ectopic pregnancy				23d. Date of delivery Month Day Year		
ed by P	Part II. Other significan	underlying cause given in Part I. 23e. Did tobacco				o use contribute to the cause of death? 2 No 3 Probably 4 PUnknown						
Completed by Phy								24a. Was	psy ormed2	prior to death?	itopsy findings available completion of cause of	
BeC	25. Was case referred o medical examiner? 26. Place of Death (Check only ope)											
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ation	27. Manney of Death 1 Panding 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Injury M 1 Yes 2 No											
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Medical Certification;	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Description of the cause(s) and manner as stated. Description of the cause(s) and manner as stated. Description of the cause(s) and manner as stated. Description of the cause(s) and manner as stated.											
Σ	29b. Signature and title	of certifier	Erler	w	Sons	29c. Licens	3 (77)	5	29d. Da	te signed (Monti	7, Day, Year) 28 208	
	30. Name and address	of person who o	ompleted caus	se of death (Ite	om 23a) (Type	Print) #11' AUSTON	2 80	LAIR R	SOR	2104	7 44	

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Registrar

State

31. Date filed (Month, Day, Year)

AUG 2 9 2008

32. Registrar's Signature

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تنبر		Physicia /Medic		Mary J.	Marskal	/			Augus		200 Year		41M
		Examin	er		re street and number) Ton Meinzer (G. 1702 7	City, Town, or	Location of Dea	th →i£	A	County of De	ARUN	DE
ì		Funeral		5. Social Security Number 6.	Sex 7. Age (In yrs.	Mon	nder 1 Year ths Days	If Under 24 Hrs Hours Min				rthplece (State	er Foreign
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		show	'n	10a/State 106. County	10c. Ci	ity, Town or Location	hin)					ity Limits
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	; §	by the a	Physician/Medical	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4 ☐ Pregnant at time of 9 ☐ Unknown	death 5 ☐ Othe	r (specify)						
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	DIVISION OF VIGILIARY PROPERTY. F.O. BOX 60/	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying Pt	nysician: To the best of my kno niner: On the basis of examina	owledge, death occu	rred at the tin	ne, date and place	ce, and due to the	e cause(s) and manner	as stated.	(s)
	t oth	ithin 24 o the F omplet	Medical	29b. Signature and title of certifier	and manner stated.		29c. License					nth, Day, Year)	
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	Ĭ	Stat	te	31. Date filed (Month, Day Year)	2. Registrar's Signa	ature	70	Jean	- 00, 10	•		2010	
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Pt Known as: Yahya Muhammad

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rector		146-28-4		™ M	2L F	70	Yrs.			01		38		″ SC
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r 28a	Director	10e. Street and Num				1		10f. Zip Code	9		10g. Cit	tizen of	What Cour	ntry?
23a c ast be		3702 Gra	ntley	Roa	d				21215			U	.S.A	•
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or i	by Fi	1 ☐ Never Marrie 3 ☐ Widowed 4		ed 1	Yes 25 Yes, Give Year or Dates	∑ No		1□Yes 🌠 N	lo Specify:			Specif	fy: B	lack
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Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 Donation			val from Sta	te i		matorý or other i	Park 8,	/29/08	W W	Cho	awn,	БМ
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 18

Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day Physician August 22, 2008 12:30 PM M Neely Alfred Moore /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Washington Neiswanger Management Services Hagerstown 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) West Virginia 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 M 2 □ F 79 1929 Aug 18, 232-34-5890 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. Counfy MD 1 ☐ Yes 2 ☐ No Washington Hagerstown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21742 14014 Marsh Pike USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) unk 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) truck driver transportation 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) unk unk Be 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Neiswanger Management Services 14014 Marsh Pike Hagerstown, MD 21742 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5. Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street 21. Signature of Euneral Supplier S. Wade Baltimore, MD cress 21201 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, wheart failure. List only one cause on each line.

Immediate Caus (Final disease or condition resulting in death)

a.

Due to (or as a consequence of): Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of) Diseas **Examiner** chron Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending neversion and use as the burial-trar Due to (or as a consequence of) as been signed by the attending physician 2 should be detached for use as the buria Division or Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2□•No 1∏ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Certification: To Be Other: 4 Unursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ Ho 1 🔲 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 Natural 5 ☐ Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) l in by t 4 Homicide 1 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0060396 8/22/04 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MINIHED ARID 31. Date filed (Month, Day, Year) ALIG 2 9 2008 32. Registrar's Signature State Registrar

			For State Registrar		State of Ma	aryland		rtment of F <i>tificate of</i>		ا Mental Hy	giene Reg. No.	2008	278	5 L
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items State of Maryland / Department of Health and Mental Hygiene 25,27,28a-f per me, 882,08/28/08dhb

Req. No. For State Registrar Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2:55 PM **Physician** OdeNWAld 2008 August Res /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** MINSTON BUKNIE HNNE HRUNDE If Under 24 Hrs. No. (Month, Day, Year) Oct. 30,1919 If Under Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday Funeral Months Days 1 □ M 2 X F 88 219-01-6137 Director MD Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, I're Medical Examinar must be redified at Director 1 ☐ Yes 2 X No MD Anne Arundel Linthicum 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 916 Lynvue Road 21090 U.S.A. Funeral death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after on and Mental Hygiene.

is marked other than "natural", or itee 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No þ Specify. Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Registered Nurse Medica1 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Thomas Rumney Albirta 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important; If item 27 is n any injury or other traun once. Mrs. Mary Pat Coppadge/Daughter 605 Elizabeth Road Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Aug. 1 2008 12, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial: Elkridge,MD. 22. Name and Address of Facility Singleton Funeral & Cremation Signature of Funeral Service Licensee Services 1 2nd Avenue SW Glen BUrnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Subdural Hematoma Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ATTON APPROVED BY MEDICAL EXAMINER Sequentially list conditions, if any leading course, it is a cause. Enter Underlying Cause (Disease or injury that initiated events Examiner bije to for as a nonsecuence of attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Récords, ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? law 24a. Was an autopsy performed The certificate 2 1 No 2 1 No Division of Vital 1 □Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) miner? 1 Yes Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director; After the completely filled in by the funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Accident Multiple falls 1 □Yes 2 No Unknown Unknown ^M 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Found: Nursing Home 28f. Location (Street and Number or Rural Route Number, Crown State) 7548 Old Telegraph Road, Odenton,MD determined 4 Homicide Road, 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) August 10, 2008 29c. License number D41365 29b. Signature and title of certifier THE MID 30 Name and address of person who completed cause of deathyflem 23a) (Type, Print) Drive, Gen Burnie, MD. 2016/

Registrar
DHMH 17 Rev 1/2001

State

32 Registrar's Signature

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Day, Year)

2008

31. Date filed (Month.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? amend #8 Per FH G883 9/28/08calle of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 28 **Physician** Year AUGU51 12:56 AM 4 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPITAL Sinai OF BALTMORE MUTMOKE 1935 9! Birthplace (State or Foreign Country) If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, **Funeral** Days Months Hours Min. 418 - 44 - 245° Usual Residence of Decedent 1 XM 2□ F **Director** death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director more 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 212 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: þ 3 Widowed 4 Divorced Black Year or Dates "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired)_ marked other than Elementary/Secondary (0-12) College (1-4or 5+) Aberdeen Kroving Ground Oliceman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be မ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Joan Baltimore, Important: If item any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 12008 en Mount Crematory 22. Name and Address of Escility
Joseph L. Russ Funeral Home, F
2222 W. North Ave. Balto Md. 21. Signature of Funeral Service Licenses 23a. Part 1 Enter the disease, or complications this caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shod, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Preumonia /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of). The law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): physician at the burial Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) been signed by the should be detached 1 □Yes 2 □ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pulmonary 1 ☐ Yes 2 ▼ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No DIABETES 24a. Was an MELLIM autopsy HYPERTENSION 2 ☑No 1 ☐ Yes or Attending Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA the funeral 27. Manrer of Death 1 ✓ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury Certification: 28d. Describe how injury occurred 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide e Funeral I Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated within 2 To the 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 29c. License number 2008 RES-60D 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HOSPITAL OF BANTMORE MANTINAN MD SINAL MICHAEL 32 Registrar's Signat 31. Date filed (Month, Day, Year) State

Registrar

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	Funeral Director		5. Social Security Number 6. Sex 224, 42, 3624 1 M	7. Age (In yrs. last I	birthday) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Month, Day, Yea		place (State or Foreign latry)
	and		Usual Residence of Decedent 10a. State 10b. County	10c. City, To	own or Location				10d. Inside City Limits
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	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Heatth and Mental Hygiene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other treumatic event. The Medical Exam are must be notified at	Funeral Director	10e. Street and Number 8070 Tidewate	in Trail	10f. Zip Code 23	75	10g. C	Citizen of What Col	untry?
	tems 2	nera	11. Marital Status 1 12.	Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? (Spe n, Mexican, Puerto F	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
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	10		30. Name and address	s of person who	o completed caus	e of death (Iter	n 23a) (Type	Print)			3.3	0	4000	4
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** 11:35AM Juani ta August vulle 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Subet Road Baltimore Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Date of Birth (Month, Day, **Funeral** Months 1 □ M 2 KF Days 212.30.2550 Director 09 24 1931 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturar", or Items 23a or 28a-f show any Injury or other traumatic event; If Item Maryland Evantine is not that at any once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore Randallstown MD 1 ☐ Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Schnaper Drive Apt. 228 USA 21133 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Completed by Specify: Black 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Sun Paper Library Micro-Film 1 echnician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) James W. Brown addie E. Douglas 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, ** or Town, State, Zip Code) 7911 Subet Road Gwendolyn Baltimore MD Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 80 28 08 Pikesville, MD 4 Donation 5 Dother (Specify) 21. Signature of Funeral Service Licenses I Name and Address of Facility Valign C. Greene Funeral SVCS Randallstown MD 21133 liberty Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heat dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician PANLIC. +11 Lance /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sioned by the attending aboverian and After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-tran Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Mo 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No 1 □ Ýes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 2 N/No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral ι 27. Manner → Death 1 ☑ Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 5 Pending investigation 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 750 Johrneder State

DHMH 17 Rev 1/2001

Registrar

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VOID

CERTIFICATE

2008-27870

SEE

CERTIFICATE #

2008 - 26988

State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No 2008 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Aonth. **Physician** atherine /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Randallstown Season's Hospice Year) 28 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, 06 13 Birthplace (State or Foreign Country) **Funeral** Min. 1 M 2 F Months Days Hours SC 80 Director 214-24-2147 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Engine in usal be notified an once. Director 1 X Yes 2 ☐ No Baltimore MD NA 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21215 3508 Liberty Heights Ave Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 ∐Yes 2 🙀 No 1 □Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐Yes 2X No Specify: Specify: þ Black 3 Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) entary/Secondary (0-12) College (1-4or 5+) Operator AT&T 10th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hattie Cockfield Lewis Finklea ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Md 21244 <u>Leola Belin-</u>Sister 2403 Hermosa Ave, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Munn Cemetery Pamplic, SC :8/30/08 22. Name and Address of Facility
March F/H West of Funeral Service Licensee mala Stry 21215 <u>4300 Wabash Ave, Baltimore, Md</u> 23a. P.rt1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** adeno carc isease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): e Hospital or Attending Physician: The law requires that the death certificate be executed 1.24 hours after death. It shours after death.

Funeral Director; After this certificate has been signed by the attending physician and burial-transit Due to (or as a consequence of): P.O. Box 68760 attending physician Physician/Medical as the t IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 9 🗆 Unknown signed I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 3 Probably 4 ☐ Unknown 1 ☐ Yes No Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 □Yes 2 No director, 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Nother (Specify) Hospital: 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Datural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No completely filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOB Date filed (Month, Day, Year) State AUG 2 9 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Day Month E1wood Francis Skipper 26 2008 5:40p August 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Carroll Hospice Dove House Westminster Carrol1 If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Hours **1√2** M 2□ F 213-42-4158 64 March 2 1944 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 ☐ Yes 2 No Carrol1 Sykesville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21784 USA 4710 Sykesvílle 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ¥Yes 2 ☐ If Yes, Give Year or Dates: 1 Never Married Married 1 □Yes 2 □XNo 1960's Specify: white 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) construction heavy equipment mechanic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lawrence P. Skipper Alma R. Wisner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Pamela J. Skipper (spouse) 4710 Sykesville Rd., Sykesville, MD 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) All County Cremation 8-31-08 Sykesville, MD 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service License P.O. Box 195 Sykesville, MD 21784 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

permit. Pages 1 and 2 & Department of Health au Important: If item 27 is any injury or other trau

Physician

/Medical

Examiner

10a. State

Director

Funeral

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Completed

MD

Funeral

Director

? is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modeal Experience, ust be notified at

i and 2 should be filed within 72 hours after of Health and Mental Hygiene.

Baltimore, Maryland 21215-0036

with

death

ng physician and as the burial-transit attending properties for use as ed by the a detached f cate has been signed page 2 should be det certificate has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be

requires that the death certificate be executed

The

P.O. Box 68760,

Division of Vital Records,

Examine Physician/Medical ģ Completed 25. Was case referred to medical

Certification: To

Medical

IF FEMALE:

23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No

> 2 No 3 Probably 4 Unknown 24a. Was an

autopsy 1 TYes 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No

examiner?	
1 ☐ Yes	2 No
27. Manner of	
1 Natura	al 5 ∏ Pei

2 Accident

4 Homicide

3 Suicide

5 Pending

investigation 6 Could not be determined

28a. Date of Injury (Month, Day, Year)

Hospital:

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28b. Time of

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check one)			Certifyin Medical
29b. Signatul	eland	title	of certifier

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated The desired in the best of my intollined at the time, date and place, and due to the cause(s) and manner stated.

| Continued of the desired 29d. Date signed (Month, Day, Year) 29c. License number

ho completed cause of death 30. Name and address of person ter Street WESTHINSTER. Mid 2115

State Registrar Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month Year 4:30AM ELIZABETH ALGUST 2008 LEHNER SMITH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner aDOD SAMARITAN HOSPITAZ BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 214-22-1927 Director Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ns 23a or 28a-f show must be notified at 1 XYes 2 □ No Director Maryland N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5504 N. Charles Street items 23a Funeral 21210 U.S.A.

14. Race - American Indian,
Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ed other than "natural", or item event, the Medical Examiner 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify. Specify: White þ 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 1 and 2 should be filed within Health and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 4 years Registered Nurse Medical Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Joseph Lehner Elizabeth Cunningham 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claire Smith 5504 N. Charles Street Baltimore, Maryland 21210 e of Disposition (Name of Date 20c. Location - City or Town, State (daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Pages 1
Department of H
Important: If Iter
any injury or ott 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) Green Mount Crematory 8-30-08 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland George or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only one cause on each line. 23a. Part1. Enter the disea , or com shock, or heart failure. List only Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPSIS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ician and burial-trans Due to (or as a consequence of): P.O. Box 68760, physician a the burial Physician/Medical as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) ☐Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by KIDHEY 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown DISEASE PULMONARY 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an DISZATE 1□ Yes 2₽No 25. Was case referred to medical examiner? Be 26. Place of Death Check onl one Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 | Yes 2 | 1 | No Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death Director: the 6 Could not be 3□ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours a

To the Funeral I 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of ATTONDING D0062239 AUGUST 27 PHYSICIAN' 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAW NAING OG , MD MOSPITAL, BALTIMORE 600 D SAMARITAN 31. Date filed (Month, Day, Year) 32/Registrar's Signature State AUG 29 2008 Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hydiene 2 0 0 8

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			For State Registrar	State of Mic	ai ylailu i		tificate of i			Reg. No.	00 21014
			Decedent's Name (First, Middle, Last	st)					2. Date of Dea Month	ith Day	3. Time of Death
	Physici /Medic		Gaye C. Shuler						August	15, 200	08 10:15 PM ^M
1	Examir		4a. Facility Name (If not institution, give	e street and number)			4b. City, Town, or		th	4c. County	
			9204 Green House				Perry				timore
	Funeral Director		219-20-9762	ex 7. Age □ M 2X F	e (in yrs. last 70	birthday) Yrs.	If Under 1 Year Months Days	II Under 24 Hrs Hours Min		, Year) , 1938	9. Birthplace (State or Foreign Country) Maryland
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Lo	cation				10d. Inside City Limits
	Manyl f sho	ō	MD Baltim	ore		Per	ry Hall				1 ☐ Yes 2√ No
	28a-	rec	10e. Street and Number		L		10f. Zip Code			10g. Citizen of W	Vhat Country?
	h with	Funeral Director	9204 Green House	Circle			212	36		US	SA
	deed mark	ner	11. Marital Status	12. Was Decedent I Armed Forces?	Ever in U.S.	13.	Was Decedent of H	ispanic Origin? (S	Specify Yes or No-	14. Race	e - American Indian, ck, White, etc.
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after deeth with the Maryland if Heelth and Mental Hygiene. Item 27 is marked other than "natural; or items 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X N If Yes, Give Year or Dates:	No.		1 □ Yes 27 No	Specify:		Specify	
5	72 h 'natu	Completed	15. Decedent's Ed (Specify only highest gra	lucation de completed)	1	6a. Deced (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most of wo	orking	16b. Kind of Bu	usiness/Industry
121	within ne hen	mpi	Elementary/Secondary (0-12)	College (1-4or 5	+)			1)			
2	filed v Hygie ther t		12 17. Father's Name (First, Middle, Last)	0		h	ousewife	18 Mother's Na	me (First, Middle,		home
ano	ould be 1 Mental I arked o	Be c	Melvin LeRoy For						Gertrude		,
7	2 should and Menis marke	ဥ	19a. Informant's Name/Relationship (19b Mailir	ng Address (Street				
Za	and 2 seeth ar		Judy Strine/daug	•		9204			rcle Peri		
Baltimore,	ages 1 and 2 ont of Heelth it: if item 27 i		20a. Method of Disposition 1 Bunal 2 Cremation 3 4 Donation 5 Qther (Specif				sition (Name of natory or other plac	Ţ	Date		City or Town, State
Baltir	permit. Pages 'Depertment of himportant: if ite any injury or of pages.		21. Signature of Furreral Service Acer Konald		ector	1		•		Baltimo	ore Street
			23d. Part1. Enter the disease, or com	plications that caused	the death. [altimore,			rest.	Approximate
1	Physician /Medical Examiner	يا	shock, a heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. LUNG Due to (or as	a consequen		ER				Interval Between Onset and Death 1 year 2 10 mm
	uted	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events	C.	a consequen	100 01).					
68760,	tificate be executed ig physicien and as the burial-transit	ledical Exa	resulting in death) Last	Due to (or as	a consequen	nce of):					
	.≡ Oυ ei		IF FCWI C		-						
P.O. Box	The law requires that the death cer ste hes been signed by the attendin page 2 should be detached for use	Physician/	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 ☐ Fetal de	ath 3	Ectopic pregnancy Other (specify)	1		23d. Dat Mor	te of delivery onth Day Year
	es that igned b	by	Part II. Other significant conditions of	ontributing to death b	ut not resultir	ng in the u	nderlying cause grv	en in Part I.			inbute to the cause of death?
ord	w require	ted							\ X \	res 2 □ No	3 Probably 4 Unknown
of Vital Records,	The law cete hes b page 2 st	Completed							24a. Was autop perfo 1 Yes	med?	Were autopsy lindings available prior to completion of cause of death? 1 Yes 2 No
/ita	Physician: Th r this certificete ral director, pag	Be (25. Was case referred to medical examiner?						ath (Check only o	ne)	
7	d s	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatie		VOutpatier		4 Nursing	Home 5X Resid		
Division o	Afte	Certification:	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b			Bb. Time o Injury	Wor	yat k? Yes 2 □ No	28d. Describe h	now injury occurr	red
Divi	tal or Attenders setter death all Director; ed in by the	Certifi	3 Suicide 6 Could not b 4 Homicide determined			e, farm, str	eet, lactory, office		28l. Location (S City or Tox		per or Rural Route Number,
	To the Hospital or At within 24 hours efter or To the Funeral Direct completely filled in by	Medicai	29a. Certifier (Check only one) Certifying Physics (Check only one) Medical Example (Check only one)	nysician: To the best niner: On the basis of and manner sta	f examination	edge, deat n and/or in	n occurred at the tir vestigation, in my o	me, date and place pinion, death occ	e, and due to the curred at the time,	cause(s) and ma date and place, a	anner as stated. and due to the cause(s)
	To t To t	Σ	29b. Signature and title dicertifier	,			29c. Licens			2	d (Month, Day, Year)
			Sin Pri				D-5	1555		8/25/	2008
			30. Name and address of person who SCIN AVNG,	completed cause of d	leath (Item 23	3a) (Type,	Print) RE DRIVE	= # 220	o; BALT	IMORE	MD 21237
16.0	Sta Registi		31. Date liled (Month, Day, Year)		ar's Signatur	θ .	will				

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** GEORGE MARVIN STANSFIELD AUG. 28 2008 7:45 Α /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 1600 FRANCIS SCOTT HIGHWAY CARROLL KEYMAR If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Age (In vrs. last birthday 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Hours Davs 1 ☑ M 2 □ F Months 217-16-1433 Director 6/25/1922 MARYLAND Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Ever, incr., ust by notified at Director 1 ☐ Yes 2 ☐ No KEYMAR CARROLL 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? USA 1600 FRANCIS SCOTT HIGHWAY 21757 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☑Yes 2 ☐ No If Yes, Give Year or Dates: ₩₩ 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify: Specify: 2 WHITE 3 Widowed 4 Divorced II Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CONSTRUCTION MASON 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be d 2 should be fi th and Mental H 7 is marked ot KRINER GEORGE R. STANSFIELD ALMA traumatic ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) WIFE Health a permit. Pages 1 and Department of Health Important: If item 27 any injury or other troones. Pages 1 and ELIZABETH M. STANSFIELD 1600 FRANCIS SCOTT HIGHWAY, KEYMAR, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) PROVIDENCE CEMETERY 8/30/08 GAMBER, MD 22. Name and Address of Facility FLETCHER FUNERAL HOME, P.A. 21. Signature of Experal Service Licensee ST., WESTMINSTER, MD 21157 254 E. MAIN Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death shock, heart failure. List only one cause a each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Unsease or mjury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed burial-tra Due to (or as a consequence of): Physician/Medical the IF FEMALE: use yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy for in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) □Yes 2 □No Ö 9 Unknown 9 Unknown 9. þ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an has page 2 autopsy certificate 2 **N**o 1 ☐ Yes Hospital or Attending Physician: 25. Was case referred to medica examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To this 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident s after death filled in by the 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier cal (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 110051924 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5. MA 2973 Manchagter Rd Marchester Heno 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Physician /Medical

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Exami'ner; ast the retified at once.

Physician /Medical Examiner Be Completed by Funeral Director

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Be Completed by Physician/Medical Examiner

Certification: To

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	e or Print in E ate of Marylan						egible.			
1 - For State Registrar	ato of ivial yiali		rtificate of			Reg. No	800	27876		
Decedent's Name (First, Middle, Last) RITA	SHIFMAN				2. Date of AUGU	ST 26,	200 ⁸ ar	3. Time of Death 2:47 PM		
4a. Facility Name (If not institution, give stree GILCHRIST HOSPICE			4b. City, Town, or TOWSO		th	4c. C	4c. County of Death BALTIMORE			
5. Social Security Number 6. Sex 198-12-4500 1 □ M	7. Age (In yrs.		If Under 1 Year Months Days	If Under 24 Hrs Hours Min		Birth Year) 2/1925	9. Birth Cou	place (State or Foreign ntry) PA		
Usual Residence of Decedent 10a. State 10b. County		y, Town or Lo						10d. Inside City Limits 1 ☐ Yes ※☐ No		
MD BALTIMOR 10e. Street and Number		DAL	TIMORE 10f. Zip Code			10g. Citize	en of What Cou			
	Vas Decedent Ever in U	.S. 13. V	212 Was Decedent of H	lispanic Origin? (Specify Yes or	No- 1	USA 4. Race - Ameri			
1 ☐ Never Married 2 ☐ Married 1	rmed Forces? □Yes 2XXNo Yes, Give ear or Dates:		If Yes, specify Cuba 1 □ Yes 2 No	an, Mexican, Pue Specify:	rto Rican, etc.))	Black, White,	etc. HITE		
15. Decedent's Educatio (Specify only highest grade cor	n npleted) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wo	orking	16b. Kin	of Business/Ir	ndustry		
12 17. Father's Name (First, Middle, Last)		Pk	ROPRIETOR	18. Mother's Na						
WILLIAM 19a. Informant's Name/Relationship (Type. F	SHAMES Print)	19b. Mailir	ng Address (Street	CLAF and Number or F			FISHMAN Town, State, Zi	p Code)		
CINDY SCHIFF / DAUGE	ITER	8224	PUMPKIN	HILL COL	JRT BA	LTIMOR	E, MD 2	1208		
1	val from State BE		osition (Name of matory or other place MEMORIAL				DALLSTO			
21. Signature of Funeral Service Ucensee		8	2. Name and Addre	TERSTOWN	N ROAD	PIKES	& BROS. VILLE,	MD 21208		
23a. P rft1 in the diseas if complication shock, or eart failure. List only one of immediate Cause (Final disease or condition resulting in death)	ons that caused the dealuse on each line. STROKE Due to (or as a consec	E	ter the mode of dyi	ng, such as cardi	ac or respirato	ory arrest,		Approximate Interval Between Onset and Death		
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consec	quence of):								
Cause (Disease or Injury that initiated events that initiated events c resulting in death) Last	Due to (or as a consec	quence of):								
in the past 12 months?	f yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of 9 □ Unknown	al death 3	□ Ectopic pregnan □ Other (specify) _	су		2	3d. Date of deli Month	very Day Year		
Part II. Other significant conditions contrib	uting to death but not res	sulting in the u	underlying cause gi	ven in Part I.		Did tobacco u 1 □ Yes 2 [the cause of death?		
					- ;	Was an autopsy performed?	24b. Were au prior to death? 1 □Yes	topsy findings available completion of cause of		
25. Was case referred to medical examiner?	ital		100	26. Place of D	eath (Check o	only one)		11-10-16		
1 ☐ Yes 2 🔼 No	tal: 1 ☐ Inpatient 2 ☐ 8a. Date of Injury (Month, Day, Year)	ER/Outpatie 28b. Time o Injury	of 28c. Inju	ry at rk?	Home 5 28d. Desc	Residence for the ribe how injury	Other (Spendocurred)	city) HOSPILE		
2 Accident investigation	8e. Place of Injury - At h	nome, farm, st]Yes 2□No	28f. Locati City o	ion (Street and or Town, State)	d Number or Ru	ıral Route Number,		
29a. Certifier (Check only one)	an: To the best of my kr On the basis of examir and manner stated.	nowledge, dea nation and/or i	ith occurred at the nvestigation, in my	ime, date and pla opinion, death o	ace, and due to	o the cause(s) time, date and	and manner as place, and due	s stated. to the cause(s)		

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

> 10 State Registrar

29b. Signature and title of certified

AUG 29

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

OANIENT DIGHT MAN, MO 16565 N CHAPLES ST, SUITE 209

31. Date filed (Month, Day, Year)

AUG 2 9 2008

32 degistrar's Signature

29c. License number

D64395

29d. Date signed (Month, Day, Year)

AUGUST 27, 2008

BALTIMORE, MD 21204

Amend Items State of Maryland / Department of Health and Mental Hygien [] [] 8

Certificate of Death

Reg. No. For State Registra 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) Day Month Year Physician 11:29 PM^M 2008 Mary Jean Topping August 11, /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year Months Days If Under 24 Hrs. Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6 Sex **Funeral** Months 1 ☐ M 2 🖾 F 49 214-78-2596 Aug 15, 1958 Director Maryland Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County or items 23a or 28a-f show MD Worcester Snow Hill 1 ☐ Yes 2X No Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 6740 Cedartown Road 21863 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No 11. Marital Status 1 Never Married 2 Married 32 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white If Yes, Give Year or Dates: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) 0 clerk hardware store other 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Deportment of Health and Mental Hy Important: if flem 27 is marked oth any injury or other traumatic event 908. Be Albert Juskus Elizabeth Prebis 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Edward Juskus/brother 9625 Whiteacre Road B2 Columbia, MD 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □Donation 5 \(\)\(\)Other (Specify) in state 21. Signature Funeral Sen ice Licencee Wade State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 8 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) failure nepatic **Physician** /Medical Due to (dr as a consequence of):
End Stage Liver Disease APPROVED BY MEDICAL EXAMINER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury CERTIFICATION APPORT Due to (or as a consequence of): Examiner burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Be Completed by Physician/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day Month in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Sinpatient examiner 1 Yes Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 2 2 ☐ ER/Outpatient 3 ☐ DOA this 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Medical Certification: Division Injury 1 Natural 5 Pending 2 No death. investigation within 24 hours after death To the Funerei Director: / completely filled in by the f 2 ☐ Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 🔁 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signatuse and title of certifier van zamond Mo D0056307 August 11, 2008 no completed cause of death (Item 23a) (Type, Print) MD, Atlantiz General Hospital, 9733 Healthnay Drive, Berlin, MD 21811 30. Name and address of person v J. vain Egmond MD 31. Date filed (Mon 32. Registrar's Signature State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year 25 Day Physician 1652 M ANNE 2008 ROSALIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HARFOR CHESAPEAKE MEDICAL Date of Birth (Month, Day, Year) 11-04-1938 9. Birthplace Country) Age (In yrs. last birthday) (State or Foreign 5. Social Security Number Days Months 1 □ M 2 1 F 215348697 69 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State 1 ☐ Yes 21 No **Funeral Director** Harford Bel Air 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 300 Sunflower Drive #129 21014 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2√∑ No Specify: Completed by 3 ☐ Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Clerk Supermarket 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Perino DeJulius Dorothy Burch ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 940 Jessicas Lane Bel Air, MD 21014 Michelle Gowland (Daughter) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Bavview Crematory 08-28-2008 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir Signature of Funeral Service Light Inc 610 W. MacPhail Rd Bel Air, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Stage disease or condition resulting in death) Respiratory Falure esquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence, Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes No Day 5 Other (specify) 9 Dunknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2230 25 1 ☐ Yes 1 □Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ER/Outpatient 3 DOA Medical Certification: To Inpatient 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated.

Records, Vital Division of Ros

The law requires that the death certificate be exec funeral director, page 2 should certificate Hospital or Attending Physician: After this within 24 hours after deatl To the Funeral Director: completely filled in by

Funeral

Director

Department of Health and Mental Hygiene. mportant: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examinal must be notified at

Pages 1 and 2

Physician

/Medical

Examiner

State Registrar 31. Date filed (Month, Day,

whamuse

29b. Signature and title of certifier

500 32. Registrar's Signature

Name, and address of person who completed cause of death (Item 23a) (Type, Print)

29d. Date signed (Month, Day, Year)

Chesapeake Dr., Bel Air, ND 21014

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Date of Death
 Month THOMMEN 0615 AUL 0 08 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Glen Burnie 1600 Tieman Drive Anne Arundel 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Months Days 160 M 2□ F 216-12-9593 June 10, 86 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No MD Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1600 Tieman Drive 21061 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 140-45 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 📉 No Specify: white 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 police officer law enforcement 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Francis Thommen Sr Mary Jane Riley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Thommen/spouse 1600 Tieman Drive Glen Burnie, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 N Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore Street onald Baltimore, MD

Physician /Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f show

'natural", or items 23a or

permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygienn Important: If item 27 is marked other the any injury or other traumatic event, its once.

Director

Funeral

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Completed

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Examiner		Constant the time and the second
cate be executed obysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Leader of the that initiated events resulting in death) Last
the death certifi by the attending I sched for use as	nysician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown
To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours alter death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical Certification: To Be Completed by Physician/Medical Examiner	Part II. Other significant conditions
ysiclan; is certific director,	o Be (25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Sertification: T	27. Manner of Death 1 Natural 5 Pending investigatio 2 Accident 6 Could not be determined
ne Hospit n 24 hours ne Funera	edical (29a. Certifier Check only one) Certifying P 2 Medical Exa
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Year)

shock, o heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	Interval Between Onset and Death
resulting in death)	Due to (or as a consequence of)	44ler
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Unspace or injury	Due to (or as a consequence of):	,
that initiated events resulting in death) Last	Due to (or as a consequence of):	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □Yes 2 □No 9 □ Unknown	23c. If yes, outcome of pregnancy 1	elivery Day Year
Part II. Other significant conditions of	contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 Yes 2 No 3 F	to the cause of death? Probably 4 Unknown
	autopsy prior to	utopsy findings available completion of cause of s
25. Was case referred to medical examiner?	26. Place of Death (Check only one)	
1 Yes 2 No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Sp	ecify)
27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of lajury at Work? M 28c. Injury at Work? 1	
3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined		Rural Route Number,
29a. Certifier (Check only one) Certifying Programme (Check only one) Certifying (Check only one	nysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner and the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and duanner stated.	as stated. re to the cause(s)
29b Signature and title of certifier	29c. License number 29d. Pate signed (Mor. 27) 29d. Pate signed (Mor. 27) 270	
me and address of pe sort who	complete Plause of death (Item 23a) (Type, Print) DEVENSE HIGHWAY ANNAY	Pour Montal

Registrar

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year JAMES TRAYLORE WILCHOM 08 1/225 AM 27 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BATIMONE VA -BILECC LOCK KINON If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, O3 08 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Social Security Number 6. Sex Year) **№** M 2□ F Months Days Hours Min. NJ218**-**42**-7**606 65 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Cecil Perryville 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21093 U.S.A. 703 Concord Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No Specify: Specify: Black 3 ₩Widowed 4 Divorced 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Baltimore City Police Officer 2yrs 12th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Cornelia Lewis Thomas William Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 928 Redbud Ct., York, PA 17404 Alesia Willies-Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison ForestVet 9/3/08 Owings Mills, Md 22. Name and Address of Facility 21. Signature of Funeral Service Licensee March F/H West 21215 4300 Wabash Ave, Baltimore, Md 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HYPOTENSION 7 incs Due to (or as a consequence of): WEERS MYOCAMPIAC INMACCTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Contonian 4 Due to (or as a consequence of):

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

MD

Funeral

Director

28a-f show

Director

Funeral

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Completed

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r than "natural", or items 23a or 28a-f shov

permit. Pages 1 and 2 should be filed within 72 hours afte Department of Health and Martal Hygiens. Inportant: If item 27 is marked other than "natural", or i any liquy or other traumatic event, it a Natical Example.

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

The law requires that the death certificate be

certificate

burial-transi Exami attending physician for use as the buria Physician/Medical sate has been signed by the page 2 should be detached Completed To the Hospital or Attending Physician: I within 24 hours after dea h.

To the Funeral Mrector After this certificat completely filled in by the funeral director, p. Be Certification: To

23b. Was decedent pregnant in the past 12 months? I □Yes 2 □ No 9 Unknown

yes, outcome of pregnancy
☐ Live birth 2 ☐ Fetal death 4 Pregnant at time of death

3 🗆 Ectopic pregnancy 5 Other (specify)

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown

Year

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

9 🗆 Unknown

ACCUMED immiNE ASTRIGUCY CENTINOVASCILAR Accident

24a. Was an autopsy performe 1 ☐Yes 2 No 26. Place of Death (Check only one)

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐Yes 2 ☐ No

25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No 27. Manner of Death

5 Pending investigation 6 ☐ Could not be 28a. Date of Injury (Month, Day, Year) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of 28c. Injury at Work?

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only

1. Natural 2 Accident

3 🗍 Suicide

4 - Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

29b. Signature and title of certifier lno

mo

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hospital:

3900 LOCH KAVEN GUD; PROTO, MD ZIZI8 CHARLES HOUSCIN 31. Date filed (Month, Day, Year)

State Registrar

Medical

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 26 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. Date of Birth (Month, Day, Birthplace (State or Foreign Country) **Funeral** Days Hours Year) Months 1 🗆 M Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ms 23a or 28a-f show must be notified at Baltimone 1 ☐Yes 2 XNo MD GWUNN Oak **Funeral Director** 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21207 Koad Rhom 651 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: items ; 14. Race - American Indian. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. Examiner 1 ☐ Never Married 2 Married 'n, Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: 30CK þ 3 Widowed 4 Divorced "natural" Completed 16b. Kind of Business/Industry Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Secondary (0-12) College (1-4or 5+) Child Care Daycare Provider 12th grade 2 years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Quees မ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Randallstown, MD 21133 Stone Road Johnson Diana J. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Memorial Park Windson Mill, MD 30/18 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Jaugun C. Greene Funeral SUCS 21. Signature of Funeral Service Licensee 8728 Liberty Randallstown MD 21133 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respirato shock, or head-failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical ue to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a nsequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending plant of the last as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by **4** □**O**nknown 1 🗌 Yes 2 No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 ▼No 24a. Was an autopsy performed' 107∭Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 ER/Outpatient 3 DOA Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 1 🔲 Inpatient Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident Director: 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide within 24 hours after To the Funeral Di completely filled in 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and/manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of the d cause of death (Item 32 Régistrar's Signature

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (1)

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Reg. No. Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 25^{Day} Physician 2008 Aug. 7:52a ™ M. Ulrich Kathern /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Baltimore Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 □ M 2 □ F 91 214-01-4549 Yrs Oct. 28, 1916 MD **Director** Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examinar must be notified at Middle River Baltimore 1 ☐ Yes 2 No MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21220 501 Holly Hunt Road Pages 1 and 2 should be filed within 72 hours after death went of Health and Mental Hygiene.
unt: If Item 27 Is marked other than "natural", or items 23s Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Never Married 2 Married 1 ☐Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ∐Yes 2 ∐No White Specify: þ 3 Widowed 4 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) own home Homemaker 10th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew Zapf MArgaret Hinkleman ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s
Department of Health ar
Important: if item 27 is
any injury or other trau 501 Holly Hunt Road Baltimore MD 21220 Lambert A. Ulrich Sr./son 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition oak Lawn Cemetery 8/28/08 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Furleral Service Licenser 300 Mace Ave. Balto. MD 21221 Connelly Funeral Home of Essex Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line he death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final Physician DAYS morme disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events as a consequence of). Examiner The law requires that the death certificate be executed ng physician and as the burial-transit P.O. Box 68760% resulting in death) Last Due to (or as a consequence of): Physician/Medical the attending p IF FEMALE: if yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) ☐Yes 2 No be detached 9 Unknown 9 Unknows signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Fart I. \$ of Vital Records, 1 ☐ Yes 2 V No 3 Probably 4 Unknown cate has been si page 2 should t Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 27No after death.

Director: After this certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes Physician: 25. Was case referred to medical examiner?
1 Yes 2 No 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Nother (Specify) NOS DIG 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) filled in by the funeral 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? Division Hospital or Attending 5 Pending investigation 1 Natural tall 1 ☐ Yes 2 🛣 No AUGUST 17 2007 UNKNOWN M 2 Accident 3 ☐ Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Thomicide 9000 FRANKLIN SQUARE DR. ROSEDALE MY HOSPITAL within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Name and address of person who completed cause of death (Item 23a) (Type, Print)

M

32. Registrar's Signature

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29c. License number

and stowers mornes

29d. Date signed (Month, Day, Year)

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/Medi Exami		4a. Facility Name (If not institution				4b. City, Town, o	r Location	of Death			unty of Death	2333
		Suburban F 5. Social Security Number		e (In yrs. last	hirthday	Beth			Date of Birt		NTGOM	
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or 28	Dire	10e. Street and Number				10f. Zip Code				-	of What Coun	ntry?
s 23a nust b	ra	10528 West					0817				J.S.A.	
Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Modical Examiner must be notified at once.	by Funeral	11. Marital Status 1 □ Never Married 2 □ Marr 3 □ Widowed 4 □ Divorced	12. Was Decedent I Armed Forces? 1 □ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Decedent of H Yes, specify Cub ☐Yes 2√∑No	an, Mexica Specify		g res or No- can, etc.)		Race - Americ Black, White, e ecify: Bla	etc.
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arke	ပု	Herman Williams Flossie Strother										
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other		20a. Method of Disposition		20b. Place	of Dispos	sition (Name of natory or other place		Dat			ion - City or To	
Iny or		1 ☐ Burial 2 🔀 Cremation 4 ☐ Depnation 5 ☐ Other (S)	3 ☐ Removal from State pecify)	_	-	Cremato		7/25,	/08	Hanc	ver,	MD
any inju		21. Signature of Funeral Service	Allowale	u.l.		246 N.	Wash	ningto	on St	,Rock		ME, P.A. ,MD 2085
	Г	23a. Part 1. Enter the disease, or shock, or heart failure. List	complications that caused only one cause on each lir	the death. D	o not ente	er the mode of dyli	ng, such as	s cardiac or I	respiratory a	rrest,		Approximate Interval Between Onset and Death
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<u>+</u>	Je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
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To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifyin (Check only one) 2 Medical	g Physician: To the best Examiner: On the basis o and manner sta	f examination	dge, death and/or inv	occurred at the ti restigation, in my	me, date a opinion, de	and place, ar	nd due to the I at the time,	cause(s) an date and pla	nd manner as s ace, and due to	stated. o the cause(s)
To th	Me	29b. Signature and title of certifier	04 /			29c. Licens	se number			29d. Date si	igned (Month,	Day, Year)
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		30. Name and address of person	/ 1			Print) George	+ 05.7	. G. c	Ro+h	മഭീച	MD 3	00814
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 88 Certificate of Death Reg. No 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a, Facility Name (If not institution, give street and number) **Examiner** Home more Sal 9. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) If Under Date of Birth (Month, Day, **Funeral** Year) Days Hours 1 ☑ M 2 🗆 F Director ardina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hylpiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, th. Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral Race · American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2ÛX No þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) /Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 10 19a, Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tanc 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ⊠ Burial 2 □ Cremation 3 □ Removal from State 12008 4 Donation 5 Dother (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Joseph Like uneral Hi 22 Ave. 23a. Part. Enter the thease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show, or heart follure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final EREBROVAS YEARS **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed attending physician and for use as the burial-transit Exami Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760. Physician/Medical 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown certificate has been s rector, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy 2 No 1□ Yes Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3□ DOA Certification: To After this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 ☐ Pending investigation 1 Tes 2 No I hours after death. 2 Accident 3 ☐ Suicide 6 ☐ Could not be determined Place of injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours at 29a. Certifier 🔯 CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar
DHMH 17 Rev 1/2001

BRIDE RD, BALTIMORE

900

egistrar's Signature

WALLAC

Year)

31. Date filed (Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Items 25,210,218Maryland Departments/ Departments/ Departments/ Mental Hygiene 1 - For A Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 5:10 AM Mams 2008 Arnold /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Care altimore Birthplace (State or Foreign Country) 6. Sex Date of Birth (Month, Day, Age (In yrs. last birthday) If Under 1 **Funeral** 966 Months 1 □ M 2 □ F -96-697 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location show 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Weden Examinar must be notified at once. 1 ☐ Yes 2 ☐ No Director Parkville 10g. Citizen of What Country? 10e. Street and Number 21234 eanwood Ad Apt 20 Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 | Yes 2 | No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 Specify: Black 3 Widowed 4 Dervorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) $\mathcal{D}A\nu\mathcal{H}$ Farnen 3 Dermor 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Miller Arnold T. Williams Florine ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) handal e of Disposition (Name of Date Date 20c. Location - City or Town, State Florine 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State King Memorial 8.26200 Baltimore, Mi) 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Vaugna C. Greene Funeral Services 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the dease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 4905 York Ad Baltimore, MD 21212 EXEMPER Immediate Cause (Final disease or condition resulting in death) Dech Le Basani **Physician** /Medical Due to (or as consequence of): Examiner Jaums Se _uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of: The law requires that the death certificate be executed burial-transit and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 ☐ Other (specify) I ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 I Inknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed this certificate 2 🗆 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Hospital or Attending Physician; 25. Was case referred to medical examiner?

1 X Yes 2 100 director, Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To nours after death.

neral Director: After this

filled in by the funeral d 28a. Date of Injury 28b. Time of 27. Manner of Death 28c. Injury at Work? Subject driver of car that Division 5 ☐ Pending investigation 12:41a M 1 Accident 12/29/2007 1 □Yes 2 No struck curb and pole. 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Loch Raven Blvd. near Deanwood Rd., Parkville, MD 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide within 24 hours a 29a. Certifier to the cause(s) and manner as stated eritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certific D31464 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NA ENTAWST SOUTH 305 BALTIMORE MITZER 826

Registrar

State

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

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Funeral			Numberunk 6. Se	x 7. A	Age (In yrs. last birt	hday) If Und	der 1 Year If Under 2	24Hrs. 8. Date of Birt	h (MM/DD/YYYY)	9. Birthplace (State or Foreign Country)
Director			1 X	M 2_F	47	Yrs. Mont	ths Days Hours	Min. June 3	3, 1961	Country)
á E	-	Usual Residence o 10a. State	10b. County		10c. City, Town	or Location				10d. Inside City Limits
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larylar 28a-f s at on	Director	10e. Street and Nu	mber			10f. Z	ip Code	11	og. Citizen of Wha	
3a or 3		926 Li	ght Stree	1			21211	0.40 -16 1/	USA	- American Indian, Black,
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Marr		Armed Force		If Yes, spec	dent of Hispanic Origin cify Cuban, Mexican, F	Puerto Rican, etc.)	White,	
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Fe, I and Healt Fitem		20a. Method of Di	sposition Cremation 3	Demoval from		of Disposition (Nation) tory or other place	lame of cemetery, ce)	Date	20c. Location -	City or Town, State
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Salti ermit Departm mports njury e		21. Sign e of F	unera vice Licer	Wad Wi	reckor	22. Name at Sta	nd Address of Facility te Anatomy	Board 655	W. Balt	timore Street
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of Vi ling Physi After this	T. To	1 ✓ Yes 27. Manner of De	2 No eath	28a. Date of (Month, D	f Injury 28b	. Time of Injury	28c. Injury at Work	? 28d. Describe	e how injury occur	red
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Division of Vital Division of Vital To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certif completely filled in by the funeral director,	Medical Ce	4 Homicide 29a. Certifier (Check only one)	O . Alfaire Bhasi	-i-ry To the best	of my knowledge, of examination and/o	leath occurred at r investigation, in	t the time, date and plan my opinion, death oc	ace, and due to the ca	use(s) and manne te and place, and	er as stated. due to the cause(s)
To To com	Med		nd title of certifier	and manner sta	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		29c. License number			ned (Month, Day, Year)
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			ddress of person wh	o completed cause sistant Medica		1) 111 Penn St	treet, Baltimore, I	MD 21201		
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State Registrar AUG 2 9 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** William E. Bare 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Washington Hagerstown 8. Date of Birth (Month, Day, April 1, If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Days Hours 1 M 2□ F 1950 161-40-1254 58 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Department of Health and Mental Hygiene. Important: filtem 23a or 28a-f show mortant: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examilization and the Medical Examilizati PA Franklin Waynesboro X∏Yes 2 ☐ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 25 North Potomac Street, Apt. 304 17268 USA Funeral filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? ⊁EM'es 2□ No If Yes, Give Year or Dates:1970- 171 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11, Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XXNo Specify. ģ 3 Wigowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) welder crane mfg. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be Clarence Bare Vivian Gsell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Ashley M. Kauffman daughter 516 Green Street Waynesboro PA 17268 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 Removal from State Green Hill Cemetery 8/26/2008 Waynesboro PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Lio ni ee 22. Name and Address of Facility Grove-Bowersox Funeral Home, Inc. 50 South Broad Street, Waynesboro 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 17268 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) strge **Physician** /Medical Due to (or as a consequence of) Examiner 10001 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a nonsequence of) physician and the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as t IF FEMALE 23c. if yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) After this certificate has been signed by the funeral director, page 2 should be detached 9 Unknown 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 1 No 1 ☐ Yes 2 ☐ No or Attending Physician; To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier

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State Registrar 0

31. Date filed (Month, Day, Year)
AUG 2 9 2008

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A212

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	/Medic	al	HAROLD G. BARRE. 4a. Fecility Name (If not institution, give s				4h City	Town or	Location o	of Death	August		2008 ounty of Death	1:10 P M
	Examir	ier	Rock Spring Villag						Hill	Joan			rford	'
	Funeral Director		5. Social Security Number 6. Sex 218–18–9814	7. Age	93 (In yrs. last b	oirthday) Yrs.	If Under Months		If Under a	Min.	8. Date of Birt (Month, Day 9/3/191	h y, Year)	9. Birth	place (State or Foreign intry) land
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	ith with th	al Director	10e. Street and Number 5538 Norrisville	Road			10f. Zip	Code 1161				10g. Citize USA	n of What Cou	intry?
36	urs after des et', or iteme marringer m	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:			Vas Deced Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe i, Puerto I	cify Yes or No- Rican, etc.)	1	. Race - Amer Black, White pec <i>ify:</i> Whi	, etc.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heeth and Mental Hygiene. Important: If tier 27 is marked other then "naturel", or iteme 23a or 28a-f show eny injury or other traumatic event, the Medical Examiner must be mittled at once.	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation	16	(Give	lent's Usua kind of wor OO NOT us	k done d	lurina most	t of workir	ng		of Business/li	e Supplies
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Mary	and 2 should I eelth and Men n 27 ie marke ier traumatic		19a. Informant's Name/Relationship (Type Richard A. Barrett)				-				Route Numbe White			ip Code) 21161
more,	Pages 1 a nent of He int: if item iry or othe		20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Re 4 □ Donation 5 □ Other (Specify)	emoval from State	20b. Place cemet	егу, сгеп	natory`or of	ther place			ate 2008		tion - City or T	own, State
Balti	permit. Departm Imports: eny inju		21. Signature of Funeral Service License	fun	11	22.	. Name and	d Addres	s of Facility	у	, Inc.,			17314
	Physician		23a. Part1. Erner ine disease, or complic shock, or heart failure. List only on Immediate Cause (Final	ations that caused e cause on each lin		not ente	1			cardiac o	r respiratory ar	rest,		Approximate Interval Between Onset and Death
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8760, 7	ate be executed hysicien and the burial-transit	dical Exa	resulting in death) Last	Due to (or as a	a consequence	e of):								
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	Hospi 24 hou Funer etely fill	edical	29a. Certifier (Check only one) 1 Certifying Physical Examination (Check only one)	ician: To the best of er: On the basis of and manner star	examination a	ge, death ind/or inv	occurred a estigation,	at the tim in my op	e, date and inion, deat	d place, a th occurre	nd due to the o	cause(s) ar date and p	nd manner as ace, and due	stated. to the cause(s)
	To the To the	Σ	29b. Signature and title of certifier	MD			290.	License 3	number	72	,	Jug u	signed (Month)	. Day, Year) 2008
	15		30. Name and address of person who con	npleted cause of de	eath (Item 23a)) (Type, F	Print)	Bel	Air	N	ary lu	40	210	14
	Sta Registr		31. Date filed (Month, Day, Year) AUG 2 9 2008	32. Registra	r's Signature	fores	L)							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2008 (First, Middle, Last)

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	/Medic		OLGA BAS	HER					AUGUST		•	11:06A M
	Examir	ner	4a. Facility Name (If not institution, gir	,			4b. City, Town, o	r Location of Dea	th	4	c. County of Dea	th
تحسي			FREDERICK MEMOR				FREDERIC				FREDERIC	
	Funeral Director			Sex 7. Agi	e (In yrs. last b	Yrs.	Months Days	If Under 24 Hrs Hours Min	. (Month, D	ay, Yea	9. Bir Co	thplace (State or Foreign ountry) 7 New York
	and w		Usual Residence of Decedent 10a. State 10b. County		10c. City, To	wn or Loc	ation					10d. Inside City Limits
	Maryl f sho	ō	New York Er	i o	Lanca							1 □Yes 為□No
	the 1	Je C	10e. Street and Number		Danca	2001	10f. Zip Code			10a (Citizen of What Co	
	3a or	Funeral Director	128 Cemetery Ro	had			14086			-	S.A.	, and the
	ms 2	ners	11. Marital Status	12. Was Decedent I	Ever in U.S.	13. W	/as Decedent of H Yes, specify Cuba	lispanic Origin? (S	Specify Yes or No		14. Race - Ame	erican Indian.
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Ž	should be f and Mental s marked or numatic eve	은		T B				Anna				
Maryland	s 1 and 2 should f Health and Mer tem 27 is marke other traumatic		19a. Informant's Name/Relationship								or Town, State, 2	
	is 1 and the street item 2 item 2		Janie Stickley, 20a. Method of Disposition	Daughter		of Dispos	Brenda	<u>a Avenu</u>	e,Ijam:		11e Mar Location - City or	yland21754
o D	Pages nent of int: If it		1x□ Burial 2 □ Cremation 3 □				ition (Name of atory or other plac				,	,
Baltimore,			4 ☐ Donation 5 ☐ Other (Special Signature of Funeral Service Lice)		Lanca		r Rural	L 8-2	7-08	Lan	caster,	New York
Ba	permit. Departr Importa any inju		michael P. M.	argulo		<u> 60</u>	<u>uyhario</u>	rd Road	d,Balti	. moi	uneral re,Mary	Chapel, P. A land21214
			23a. Part 1. Enter the disease, or com shock, or heart failure. List only	plicétions that caused one cause on each lin	the death. Do	not ente	r the mode of dyin			errest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a conse	Stive	/	least	1911	ure			Onset and Death
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	1000	er	Sourcentially list conditions	b. Due to (or as	a consequence	MO	114					
6	nsit	i.	So upper list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that is its lead earns to that is its lead earns to the conditions and in the cause of the conditions are the cause of the	500 to (0) as		1 1						
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200	tificat g ph) as the	Medical					- 1					
ŏ	h cert endin use a		IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	of pregnancy			7			23d. Date of del	ivery
. Bo	deat le atte	Physician	in the past 12 months? 1 □ Yes 2 □ No	1 ☐ Live birth 4 ☐ Pregnant at	2 □ Fetal deat time of death		Ectopic pregnancy Other (specify)	/			Month	Day Year
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ecords,	equire								1 🗆	Yes	2 □ No _3 □ Pr	obably 4 ☐ Unknown
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י ב	The ate h page	E O							autoj perfo 1 □ Yes	psy rmed? 2 X N	death?	completion of cause of 2 □No
VITAI	sian: ertific ctor,	Be	25. Was case referred to medical examiner?					26. Place of Dea	ath (Check only o	-/- -	10163	ZLINO
5	hysic his o	2	1 ☐ Yes 2 No	Hospital: 1 Inpatie	nt 2 ER/O	utpatient	3 □ DOA Othe	er: 4 🗆 Nursing H	Home 5 ☐ Resi	dence	6 ☐Other (Spe	cify)
	ng P		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injur (Month, Day		Time of Injury	28c. Injury Work	/ at ?	28d. Describe	how inj	ury occurred	
VISION	tendi eath. or: A	cati	2 Accident investigation					res 2□No				
	tal or Att s after d al Direct ed in by	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	ry - At home, fa . <i>(Specify)</i>	arm, stree	et, factory, office		28f. Location (City or To	Street a vn, Sta	and Number or Ru te)	ıral Route Number,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hourst after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	29a. Certifier (Check only one) Certifying Physical Example (Check only one)	ysician: To the best on the basis of and manner state	examination a	e, death on the nd/or inve	occurred at the tin estigation, in my of	ne, date and place pinion, death occu	e, and due to the urred at the time,	cause date a	(s) and manner as nd place, and due	s stated. to the cause(s)
	withii	Me	29b. Signature and title of certifie?				29c. License	number		29d. D	ate signed (Monti	h, Day, Year)
N.) /// -	M	D		DAG	6087	7 /	0 5	8/23	12008
•	,	İ	30. Name and address of person who	completed cause of de	eath (Item 23a)	(Type, Pr	rint)	3 - 0 /	-		, ,	2
	6		TAN MI	chelle	,				- 50			
Ė	Stat	ie	31. Date filed (Month) Day, Year)	Registra	r's Signature	door	r e					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legiple. State of Maryland / Department of Health and Mental Hygienes Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** CATHERINE VIRGINIA BATTLE 2008 AUGUST 10:41 AM /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death HARFORD MEMORIAL HOSPITAL HARFORD HAVRE DE GRACE 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🕱 F Davs Hours 90 Yrs 217-16-3899 **Director** FEB 28, 1918 MARYLAND Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 23a or 28a-f show 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatte event, the Medical Examiner must be notified at once. Director 1X Yes 2 □ No MARYLAND HARFORD **ABERDEEN** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 754 BATTLE AVENUE 21001 USA Funeral 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 🔀 No Specify Specify: BLACK \$ 3 Nidowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) VETERANS COMMUNITY CAREGIVER RESIDENCE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) LLOYD PARKER ROSE GREEN ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARTHA GILBERT / SISTER 101 BUSH CHAPEL ROAD, ABERDEEN, MARYLAND 21001 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State MT CALVARY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 08/22/08 ABERDEEN, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility UNERAL HOME, P.A. 552 LEWIS STREET, HAVRE DE GRACE, 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine P.O. Box 68760 law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mor Month Year Day 4□Pregnant at time of death 5 ☐ Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perforr Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner Certification: To 1 | Yes 1 Inpatient 2 CR/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural in 24 hours after the Funeral Director; After Funeral Director; After funeral filled in by the f 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the within 2 29b. Signature and title of certifier 29c. License number

State Registrar

CUR

of person who completed cause of death (Item 23a) (Type

d (Month, Day, Year) AUG 1 8 2008 20b. Place of Disposition (Name of cemetery, crematory or other place)

Huntt Crematory

20c. Location - City or Town, State

Waldorf, Maryland

08/15/2008

20a. Method of Disposition

1 ☐ Burial 2 XI Cremation 3 ☐ Removal from State

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

AUG 15

4 ☐ Donation 5 ☐ Other (Specify)

Physician /Medical Examiner

requires that the death certificate be executed

Hospital or Attending

MR 5

Division or Vital Records, P.O. Box 68760,

within 72 hours after death

Baltimore, Maryland 21215-0036

attending pl sign within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

			<u> </u>			•	
	21. Signature of Funeral Gervice Liver	Plan # M01436 Hur	Name and Address of Facility Itt Funeral Home	3035 01d Waldorf,	Washingt Maryland	on Road . 20601	
	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	iplications that caused the death. Do not enter one cause on each line.	the mode of dying, such as cardia	c or respiratory arrest,		Approximate Interval Between Onset and Death	
ucal Examine	Due to (or as a consequence of): Due to (or as a consequence of):						
Iyaiciai i/ Iviet	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23d. Date of deli Month	ivery Day Year				
בוכח שא ר	Part II. Other significant conditions of	contributing to death but not resulting in the und	erlying cause given in Part I.	1 ☐ Yes	2 No 3 Pr	the cause of death?	
	05 W			24a. Was an autopsy performed 1 Yes 2	death?	topsy findings available completion of cause of 2 ☐ No	
3	25. Was case referred to medical examiner? 1	Hospital: 1 Inpatient 2 ER/Outpatient		ath (Check only one)			
TION I	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury 28b. Time of Injury 1	28c. Injury at Work? M 1 Yes 2 No	lome 5 Residence 28d. Describe how in		oify)	
	3 Suicide 6 Could not be 4 Homicide determined	building, etc. (Specify)		28f. Location (Street City or Town, St	ate)		
100	29a. Certifier 1 ☐ Certifying Ph (Check only one) 1 ☐ Medical Exam	nysician: To the best of my knowledge, death of niner: On the basis of examination and/or inveand manner stated.	occurred at the time, date and plac stigation, in my opinion, death occ	e, and due to the cause urred at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)	
	29b. Signature and title of certifier	Lowo	29c. License number		Date signed (Month		

Registrar DHMH 17 Rev 1/2001

State

William D. Boyd, II, MD., 25365 Point Lookout Road, Leonardtown, Maryland, 20650

			For State Registrar	State of Maryland	d / Depa	artment of H	lealth a D <i>eath</i>	ınd Me		ienę () () 8	27893
			Decedent's Name (First, Middle, Last,)				2.	Date of Deat		3. Time of Death
	Physicia		James Joseph C	allahan				A	Month UGUふえ	13, 2008	12:19 AM
	/Medic Examin		4a. Fecility Name (If not institution, give			4b. City, Town, or	Location of			4c. County of De	
	Examin	e.	Caring Hands, 12	10 Grissish Pl	ace	Belcamp)			Harkor	d
Н	Eumanal		5 Social Security Number 6. Se	x 7. Age (In yrs. la		If Under 1 Year	If Under 2	24 Hrs. 8	Date of Birth (Month, Day,		
	Funeral Director		042-44-8010	XM 2□F 66	Yrs.	Months Days	Hours	Min. 1	0/25/1	941 No.	Sirthplece (State or Foreign Country) 10th Conoling
821			Usual Residence of Decedent								
	ylan		10a. State 10b. County	10c. City	, Town or Lo	ocation					10d. Inside City Limits
	Mar Mar	to	MD Harofrd	ł.	laure	de Grace					1 XYes 2 ☐ No
	n the	Director	10e. Street and Number			10f. Zip Code			1	0g. Citizen of What	Country?
	death with the Maryland ms 23a or 28a-f show r must be notified at	O Te	511 Lighthouse C	owit		2107	8			u.s.A.	
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U.S Armed Forces?	3. 13.	Was Decedent of H	ispanic Orig	gin? (Specif	y Yes or No-	14. Race - Ar Black, W	merican Indian, hite etc
٥	after des or Itams		1 Never Married 2 Marned	1 ☐ Yes 2X No	Ì		Specify:	,	,	Specify:	White
2		1 by	3 Widowed 4 Divorced	If Yes, Give Year or Dates:							
h	72 hours natural;	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed)	16a. Dece (Give	dent's Usual Occup kind of work done o DO NOT use retired	ation during most	t of working		16b. Kind of Busines	ss/Industry
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	d of H	Be	17. Father's Name (First, Middle, Last)							Maiden Sumame)	
<u>z</u>	Meni	ပ္	James W. Callaha						rry Fis		
<u>a</u>	s 1 and 2 should f Health and Mer Item 27 is marke other traumatic		19a. Informant's Name/Relationship (T)			•				co Change	
≥	and ealth m 27		Edith M. Hewitt				JOSEPH	Nu.,		de Grace, 20c. Location - City	
ore Ore	Pes 1		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ I	Computal from State	imetery, cre	osition (Name of matory or other place		Dat			
Ē	Pag ment ant: ury c		4 ☐ Donation 5 ☐ Other (Specify,	R.A.	Ferri	s & Co., I	inc. 0	18/14/	2008	West Ches	žer, PA
ga	permit. Pages Department of Important: If I any injury or once.		31 Signature of Funeral Service Licens	2 11						neral Hom	0.157
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	nysician /Medical Examiner). 	23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions.	a. Due to (or as a consequence) Due to (or as a consequence)	ence of):		ig, such as	cardiac of 1	espiratory arri	631,	Approximate Interval Between Interval Be
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O. Box 6	at the death certifica by the attending ph tached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnal 1 Live birth 2 Fetal 4 Pregnant at time of de 9 Unknown	death 3[⊒Ectopic pregnancy ☐ Other (specify) _	у			23d. Date of Month	delivery Day Year
ב	res that tigned by	'Ph	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the u	inderlying cause giv	en in Part I.		23e. Did to	bacco use contribute	e to the cause of death?
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Š	w require been sig should b	Completed							24a. Was a	an 24h Were	autonsy findings available
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Vita	sician: certific rector.	Be	25. Was case referred to medical examiner?	Hospital:		oth	an .	BEST STE	Check only or		===
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	ding I	ion	1 Natural 5 ☐ Pending	(Month, Day Year)	Injury	Wor	rk? Yes 2. ☐				
Division	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be determined 28. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28. Place of Injury - At home, farm, street, factory, office City or Town, State)							r Rural Route Number,	
	Hospital 24 hours Funaral stely filled	Medical C		ysician: To the best of my kno- iner: On the basis of examinal and manner stated.							
	ithin 2 ithin 2 itha imple	Mec	29b. Signature and the of certifier	A A		29c. Licens	se number		2	29d. Date signed (M	onth, Day, Year)
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30	Sta Regist		31. Date filed (Month, Day, Year)	3. Registrar's Signa	ture	all ?		U			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 0917 M 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Niconia 39/15/414 Mediese KAGIONAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) **Funeral** Hours Months Davs M 2□ F aMARYLAND Director 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 28a-f show s 23a or 28a-f shov Yes 2 No **Funeral Director** UNNE Omer 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with Avenue omerse 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 Mayes 2 □ No 1942 -14. Race - American Indian, item 27 is marked other than "natural", or items other traumatic event, the Medical Examination Black, White, etc. 1 AYes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: BIACK altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by 3 Widowed 4 □ Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) DRIVE ONTRACT 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Be is marked ot ORNI ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Alexandria, 102 6425 LMOND HWYUNIT 206. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Department of H Important: If ite any Injury or otl 1 Burial 2 ☐ Cremation 3 ☐ Removal from State **4** □ Donation 5 □ Other (Specify) Bennie Name and Address of Facility 21. Signature of Funeral Service Lice Smith Home FUNERAL Approximate Interval Between Onset and Death 23a. Part 1. Effer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final AXVID **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (bisease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be execute been signed by the attending physician and should be detached for use as the burial-trar Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 5 ☐ Other (specify) P.0. 9 D Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖫 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b lirector, page 2 sl autopsy performed? Yes 2 ☑ No 1 □ Yes 1 □Yes 2 🗆 No director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1K Yes 2 □ No 1 ☐ Inpatient 2 K ER/Outpatient 3 ☐ DOA Medical Certification: To this ō 28a. Date of Injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completely filled in by the funeral 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division 1 X Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Redical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifie and manner stated 29d. Date signed (Month, Day, Year) 29c. License number +IVA 29b. Signature and the 8/10/28 1+50497 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Aris Snyder SAlisbury . Md. 21801 Carrell St. 100E Registrar's Signature 31. Date filed (Month, Day, Year) State **AUG** 15 Registrar

1 - State AMEND#20bperFH8-12-08, EMW, MoCo Reg. No. 2 U U 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 9, 2008 **Physician** 3:45 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Montgomery General Hospital 01 ney If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 9. Birthplace (State or Foreign Country)
Massachusetts 8. Date of Birth (Month, Day, June 3, 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 91 Director 012-18-4745 Usual Residence of Decedent and 2 should be filed within 72 hours after death with the Maryland leath and Mental Hygiene.

m 27 is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location other traumatic event, the Medical Examiner must be notified at 1 □Yes 2 No Funeral Director Maryland Montgomery Silver Spring 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20906 United States 3701 International Drive 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White 3altimore, Maryland 21215-0036 1 ☐ Yes 2 💢 No Specify: Be Completed by 3 V☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) 5+ Elementary/Secondary (0-12) Legal Attorney 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nathan Chapper Mollie Rubenstein ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 Fallstaff Road, Baltimore, MD 21215 permit. Pages 1 and 2.
Department of Health an.
Important: If item 27 is m. any injury or other 19a. Informant's Name/Relationship (Type. Print) Bruce Chapper, Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 8-11-08 1 N Burial 2 Cremation 3 Removal from State King David Memorial Garden 10/11/08 Falls Church, VA 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee Torchinsky Hebrew Funeral Home 254 Carroll St., NW, Washington, DC 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of). Division of Vital Records, P.O. Box 68760. Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Left Myo Fra 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 PNO 1 ☐ Yes 2 No 1 ☐ Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1⊠Natural 5 Pending 04/27/2008 Unknown M Subject fell. 1 ☐Yes 2 🛣 No investigation within 24 hours area. To the Funeral Director: A 2 XAccident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Nursing Home 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3701 International Drive, Silver Spring, MD 4 Homicide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend Items 23aPt1,25,27,28a-f per me, g882,08/28/08dhb

State of Maryland / Department of Health and Mental Hygiene

DHMH 17 Rev 1/2001

Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Richard Weinstein 15275 Shary Gove Road

Registrar's Signature

& Weshotan

AUG 12 2008

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 15 15 2008 Letterio Carlo August /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll County General Hospital Westminster Carroll If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 1 **X**M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign **Funeral** $10/5/1921^{\text{(Month, Day, Year)}}$ Months Egypt 86 Director 592-44-1628 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show notified at 1 ☐ Yes 2 No Directo Woodbine Howard 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ms 23a or 21797 848 The Old Station Ct. USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 22 No If Yes, Give Year or Dates: "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ Specify: 3 Widowed 4 Divorced White Completed other than "natur 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 4yrs Consular Official Italian Consulate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 27 is marked c Rosario Carlo Luigia Ballarin 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i 848 The Old Station Ct. Woodbine, Md. 21797 John Carlo/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If ite any injury or ot once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Ardent Crematory 8-16-2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Show Co 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) CARDIDVASCULAR DISEASE ATHERO SCLERATIC **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) The law requires that the death certificate be executed physician and the burial-transit Exami Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760 Physician/Medical attending ph I for use as t IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) signed by the a I□Yes 2□No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by MEMOR 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has lirector, page 2 s perform 1 ☐ Yes 2 ☐ No Yes 2 No or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 30 DOA မှ 28a. Date of Injury 27. Manner of Death 28b. Time of 28c. Injury at Work? Medical Certification: 28d. Describe how injury occurred After 5 Pending investigation (Month, Day Year) 1 XNatural after death.

I Director: A
d in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 🗴 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and att 29d. Date signed (Month, Day, Year) August 15, 2008 30. Name and a ROUTE 97 SUTTE 10 GLENWOOD MD 21738

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day,

AUG 1 8 2008

			1 - For State Registrar	State of Ma	arylan	•			ealth a Death	ind M		Reg. No.	008		897
	Physici /Medio		1. Decedent's Name (First, Middle, Las Esther M. Cohen	st)							2. Date of De Month August	Day			of Death
1	Examin		4a. Facility Name (If not institution, give Potomac Valley Nu		<u> </u>			F	Location o	ille				ntgome	
	Funeral Director		5. Social Security Number 6. Social Security Number 6. Social Security Number 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	9X 7. Age	95	last birthday) Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birt (Month, Da April	y, Year)	913	Sirthplace (Sta Country) Mary1	
	Maryland -f ehow	tor	10a. State 10b. County	gomery	10c. Cit	y, Town or Lo	cation	Chev	y Cha	ase					e City Limits
	n with the 3a or 28a	I Director	10e. Street and Number 8100 Connecticu	t Avenue,	Apt.	324	10f. Zip	Code	20815	5		10g. Citi	zen of Whaf	Country?	
036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow fra Mudical Evel "Lier trial Le i collified al	by Funeral	11. Marital Sfatus 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced	12. Was Decedent Armed Forces? 1 □ Yes 2 反 I If Yes, Give Year or Dates:			Was Dece If Yes, spe 1 Yes	cify Cuba	ispanic Origin, Mexican Specify:	gin? (Spe , Puerto f	cify Yes or No Rican, etc.)	9	14. Race - Ar Black, W Specify:	merican Indiar hite, etc. Whit	
21215-0036	within 72 ho plane. r than "natur ine Medical.	Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12	ducation de completed) College (1-4or 5	5+)	16a. Dece (Give life.	kind of wo DO NOT u	ork done d se retired	during most	t of workir	ng		nd of Busine	ss/Industry	ent
Maryland 2	uld be filed Mental Hyg irked other	To Be C	17. Father's Name (First, Middle, Last)	nuel Manst	of				18. Mothe	r's Name	(First, Middle, Rebec		Sumame) Freedma	an	
Baltimore, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Iteme 23a or 28a-1 show any injury or other traumatic event, the Medical Exertinating the colling at an ance.		19a. Informant's Name/Relationship (1) Robert N. Col 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 ☒ 4 □ Donation 5 □ Other (Specify	nen, Son	20b. F		R Pot	omac me of other place	Plac	e, A	Pt. 806	20c, Lo	Potoma cation - City	or Town, State	20854 • irginia
Baltir	permit. P Departme Importan any injur		21. Signature of Funeral Service Licen	Dtour	mu	D ²² 11 م	Name a nzan: 70 Re	nd Addres Sky-(ockvi	ss of Facilit Goldbe	erg M Pike,	lemoria Rockv	l Ch ille	anels.	Inc.	20852
760,	Physician and Medical Examiner physician and step p	dical Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Pneumoni Due to (or as Due to (or as Due to (or as Due to (or as C. Due to (or as	La a conseq 1 a conseq	uence of):	er the mod	de of dyin	g, such as	cardiac o	r respiratory a	rrest,			Between and Death
.O. Box 68	death certif e attending id for use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	Ideath 3	∃Ectopic p ∃ Other (s		,				23d. Date of Month	delivery Day	Year
۵.	The law requires that the ate has been signed by th page 2 should be detache	by	Part II. Other significant conditions of	contributing to death b	ouf not res	sulting in the u	nderlying	cause giv	en in Part I		1	tobacco i Yes 2		e to the cause	
Records,	The law re cate has bee page 2 sho	Completed									24a. Was auto perfo 1 Yes	psy ormed?	prior		ngs available of cause of
Vital	ician: Th certificate ector, pag	Be (25. Was case referred to medical examiner?	11				104		of Death	(Check only	one)			
ot	ding Phyen. After this funeral dis	tlon: To	1 Yes 2X No 27. Manner of Death 1X Natural 5 Pending 2 Accident Investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		28c. Injur Wor	4 57 140	:	me 5 ☐ Resi 28d. Describe			Specify)	
Division	al or Attences after death	Certification;	3 Suicide 6 Could not b 4 Homicide determined	e George of Inc	jury - At h tc. (Speci	ome, farm, st	reet, facto	ry, office			28f. Location (City or To			Rural Route	Vumber,
	To the Hospital or At within 24 hours after of for the Funeral Direct completely filled in by	edical (nysician: To the best niner: On the basis of and manner st	of examina										se(s)
)	To the H within 24 To the Fi complete	W	29b. Signature and title of certifier	Den	وا	Ø M	0	D382	e number 262					onth, Day, Ye.	
	ン 		30. Name and address of person who DR. A. Mendhiratt	a, 2401 Re	esear	ch Blv		uite	330,	Rock	cville,	Mar	yland	20850	
100000	Sta Regist	ate rar	31. Date filed (Month, Day, Year) AIG 15 200	Registr	rar's Sign	ature	S.								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Ethel Mae (deman Aug 2145 1 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomica Salisburg isburu Rehab & Nursingctr. If Under 1 Year | If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2**Ø**F 219-07-3811 07/16/1906 Director Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County iral", or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Dorchester MD Director Vienna 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S. A 115 Middle Street 21869 Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0036 Specify: Specify: Black Completed by 3 ₩idowed 4 Divorced "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) other than "natu 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) John Wright Cannery Laborer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Martha Collins Edward Dennis eorae ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Middle Street 51869 Ernest Coleman Vienna MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 R 3 □Removal from State 8-17-08 Rhodesdale, Lem 22. Name and Address of Facility Bennie Smith Signature 917 W. ISAbell A St FUNERAL Home 21801 SAlis bury, md 23a. Part1. En The dise shock, or heart fail r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. Immediate Cause (FIMI **Physician** er L disease or condition resulting in death) /Medical Due to (or as consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or a a consequence o) Division or Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a ☐Yes 2☐No 9⊡Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 | Yes 2 | No 3 | Probably 4 | Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 ☐ Yes 2 ☐ No performed To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, t 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No Hospital: 1 ☐ Inpatient Other: 4 A Wursing Home 5 Residence 6 Other (Specify) 1 Tyes 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MID ft. William Robins. 2000 1 5 State 2008

Registrar

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	ath w	ral	17816 Woodval	e Ct					21740					S.A.			
	ier de Items	Funeral	11. Marital Status 1 □ Never Married 2 □ M	Agrical	12. Was Dec	edent Ever	r in U.S.				anic Origin? (S Mexican, Puer	Specify Yes or N to Rican, etc.)	lo-		ck, White,	can Indian, , etc.	
36	d within 72 hours after death with the Maryland jene. Jene. r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at	by	3 Widowed 4 □ Divor		1 X Yes If Yes, Gi Year or D	ve ates:		1	I□Yes 2🏞	No S	Specify:			Specif	jy: Т.Л-	nite	
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VII	sician: The law certificate has t irector, page 2 s	Be C	25. Was case referred to med examiner?	lical						26	6. Place of De	ath (Check only					
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Slon	teath death tor: the f	cati	Z LI Accident	estigation	0	of injune	At home 6	form otre			s 2 □ No	006 11	(0)	141		15	
\leq	or A after of Direction by	Certification:	4 ☐ Homicide det	ermined	build	ing, etc. (S	Specify)	iaiii, sire	eet, factory, offi	ce		City or To			ber or Hur	al Route Number	r,
_	spital ours a eral filled		29a. Certifier 1 Certi	fvina Pl	vsician: To the	best of m	v knowledo	ne. death	occurred at the	e time.	date and plac	e, and due to the	e cause	e(s) and m	anner as	stated	
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fur	edical	(Check only 2 ☐ Medi	cal Exa	miner: On the b	asis of exa ner stated.	mination a	and/or inv	estigation, in m	ny opini	ion, death occ	urred at the time	e, date a	and place,	and due	to the cause(s)	
	To th To th	Me	29b. Signature and title of cer	tifier		$\overline{}$,		29c. Lice	ense nu	umber		29d. [Date signe	ed (Month	, Day, Year)	
1			1 ful	0	. 11		1	$\overline{}$	V.	7 3	1623		A.	0	1 1	(4).	3-11 9
	11.2		30. Name an address of pers	son who	completed caus	e of eath	(Item 233)	ype, F	Print)		1 1	^	1 10	70.	-	1	0 (
9	H- フ	1	fredery	1+	FAS	SIII	mi	21	111101	M	deel	Camp	us	(5	e 1	tegen.	low
	Sta		31. Date filed (Month, Day, Ye			Registrar's	Signature					•		1	ı	la. A	
	Registr	аг	AUG	20	2008	1000	e d	1	Agord 1	<u> </u>						nns	

DHMH 17 Rev 1/2001

Division or Vital Records, P.O. Box 68760, or Attending Physician: After

ugan

Certification: To

Medical

reral Director: To the Funeral I within 24

27. Manner of Death 28a. Date of Injury (Month, Day Year) 5 ☐ Pending investigation 1 Natural 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide

28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide

28f. Location (Street and Number or Rural Route Number, City or Town, State)

(Check only one) 29b. Signature and title of certifier

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

10053110

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DENNIS DESHIELDS, M.D. 219 SOUTH WASHINGTON STREET, EASTON, MD 21601

31. Date filed (Month, Day, Year) State Registrar

29a. Certifier



Certificate of Death

Reg. No. 2008

29d. Date signed (Month, Day, Year)

Physician
/Medical
Examiner

1. Decedent's Name (First, Middle, Last)

2. Date of Death AUGUST 13, 2008

Funeral Director

Directo

Funeral

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Completed

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Examine

Physician/Medical

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Completed

Be

2

Certification:

Medical

29a. Certifier

(Check only one)

Andrew

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

AUG 15

r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified ≇t

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

Hospital or Attending Physician: The law requires that the death certificate be executed attending physician certificate this After 1 24 hours a within 2 To the

Division or Vital Records, P.O. Box 68760,

JERYLE VIRGINIA WILLIAMS DORSEY 6:23 P M 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death FORT WASHINGTON PRINCE GEORGES 1618 TAYLOR AVENUE 8. Date of Birth (Month, Day, Year)

JUNE 22, 1949 WASHINGTON, D.C. If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours 1 □ M 2**V**□ F Months 59 212-54-7202 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits 1X Yes 2 No MARYLAND PRINCE GEORGES FORT WASHINGTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1618 TAYLOR AVENUE 20744 UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Z No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12)
12TH GRADE College (1-4or 5+) CLAIMS SPECIALIST FEDERAL GOVERNMENT 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) DANIEL J. WILLIAMS IDA MAE HOANEY WILLIAMS WOODS 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1618 TAYLOR AVENUE, FORT WASHINGTON, MARYLAND 20744 EMERSON DORSEY / HUSBAND 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State SMITH CHAPEL CHURCH CEM. 4 ☐ Donation 5 ☐ Other (Specify) AUGUST 19,2008 PISGAH, MARYLAND 21. Signature of Funeral Service Licenses 22 Name and Address of Facility
THORNION FUNERAL HOME, P.A.
3439 LIVINGSTON ROAD, INDIAN HEAD, MARYLAND 20640 LYDIA C. THORNION JOHNSON MO0583 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an performed? 0 2 **N**0 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

State Registrar and manner stated.

32. Fegistrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

30124

Old Branch Ave

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2008 Year August 9, 8:49 Рм **Physician** Loretta Clay Dabney /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Shady Grove Adventist Hospital Rockville Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day 5. Social Security Number 7. Age (In vrs. last birthday) Funeral Months Days Hours 1 □ M 2 🖾 F 1925 Oklahoma 569-28-4816 82 Dec. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County the Marylan 10a State ral", or Items 23a or 28a-f show Examiner must be notified at 1 XYes 2 No Montgomery Village Maryland | Montgomery Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 20886-3930 United States 19204 Drumridge Circle Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S Armed Forces? 11. Marital Status 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 🙀 No Specify: Specify: <u>ک</u> White 3 ☐ Widowed 4 ☐ Divorced "natural" Completed 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) d other than "natu (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker Ith and Mental Hygier
7 is marked other th
traumatic event, Ins 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Coy Adams Onlia Clay ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,\,20886$ 19a. Informant's Name/Relationship (Type. Print) Department of Health ar Important: If Item 27 is any injury or other trau once. 19204 Drumridge Circle, Montgomery Village, MD Joe M. Dabney (Husband) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Souls
Cemetery August 15, 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Germantown, MD 4 ☐ Donation 5 ☐ Other (Specify) 2008 22. Name and Address of Facility DeVol Funeral Home, 21. Signature of Fundal Service Vio nsee 10 E. Deer Park Drive, Gaithersburg, MD 20877 Price if ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Part 1 shop Cardio vascular Dilagre Imm dia sus 4 nal disea or condition resulting in death) adpresosciesopc Physician / /Medical Due to (or as a consequence of): Examiner Discare ONCHON, Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a densequence of) burial-trar attending physician for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day in the past 12 months?
1 ☐ Yes 2 No
9 ☐ Unknown 5 Other (specify) 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 1 TYes 2 000 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be (Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 XNo 1 ☐ Inpatient 2 ★ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? Injury 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by determined 4 Homicide within 24 hours at To the Funeral D completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Pani DHILESEMD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Drive Germanteun mo 20874 19529 Dactors 20NH 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 15 Registrar 2008 AUG

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** AUGUST 11, 1:12 A^M 2008 GENE ERNEST FLEMING, SR. /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FORT WASHINGTON HOSPITAL PRINCE GEORGES FORT WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day. JULY 4, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1947 X□M 2□F 61 WASHINGTON, DC Director 219-46-7913 Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 77 is marked other than "natural", or items 23e or 28e-f show traumatic event, the Medical Experiment must be notified at 1X Yes 2 □ No Director PRINCE GEORGES OXON HILL 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number UNITED STATES 6405 ST. BARNABAS ROAD 20745 Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? ☐Yes **X**☐No Yes, Give 1 Never Married 2 X Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: 3 Widowed 4 Divorced BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) AUTOMOTIVE 10 MECHANIC 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) nd Mental marked o Pages 1 and 2 should be LENA ALBERTA WARRICK FLEMING FRANCIS AUGUSTA FLEMING 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEAN FLEMING/DAUGHTER 1107 KENNEBEC ST., OXON HILL, MD 20745 item 27 i other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. HERITAGE MEMORIAL CEM. 8/19/2008 WALDORF, MARYLAND `4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee THORNTON FUNERAL HOME, P.A. LYDIA C. THORNTON JOHNSON MODES 3439 LIVINGSTON ROAD, INDIAN HEAD, MD 20640 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician Asherosclenka /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. physician Completed by Physician/Medical as the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Tes 2 No 3 Probably 4 MUnknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed page 2 ☐ No certificate 1 Yes 2 300 1 Tyes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 → No 1 🔲 Inpatient 2 ☐ R/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) funeral 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. hours after death 6 Could not be determined 3 🗀 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 - Homicide within 24 hours a To the Funeral D 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical completely (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 08 uch 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hengumen Mesbahi 120 32. Pogistrar's Signature. 31. Date filed (Month, Day, Year) State AUG 15 2008 Registrar

			For State Registrar	State of Ma	ryland / Depa <i>Cer</i>	artment of He rtificate of D			giene Reg. No. 🤈	008	27901
燕	Physici	an	Decedent's Name (First, Middle, MA	Last) RY E. GARDNE	īR			2. Date of Dea Month AUGUST	Day 14	2008	3. Time of Death 9:59 A M
	/Medic Examin		4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death			ty of Death	J.33 A
d.	LAGIIIII		604 TROUT DALE	TERRACE		BEI	AIR			HARF	ORD
第2	Funeral		,	5. Sex 7. Age 1 M 2 XF	(In yrs. last birthday) 86 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birtl (Month, Da)	r. Year)	Coun	**
þ.	Director		084–20–0763 Usual Residence of Decedent		00			AUGUST	0, 192	4 NEW	JERSEY
	yland now at		10a. State 10b. County		10c. City, Town or Lo	cation				10	Od. Inside City Limits
	e Ma 3a-f sl	cto	MARYLAND :	HARFORD		BEL	AIR				1 X Yes 2 No
	vith th	Directo	10e. Street and Number			10f. Zip Code	04.04.4		10g. Citizen o		try?
	eath v	Funeral	604 TROUT 1	DALE TERRACE 12. Was Decedent E		Nas Decedent of His	21014	pecify Yes or No-	14. R	USA ace - America	an Indian.
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show amy injury or other traumatic event, the Medical Examiner must be notified at once.	by Fun	1 Never Married 2 Marrie 3 Widowed 4 Divorced	Armed Forces?	0	Was Decedent of His f Yes, specify Cubar 1 ☐ Yes 2 【XNo	Specify:	o Rican, etc.)	Spec	lack, White, o	
5-0036	2 hou latura lcal E		15. Decedent's	Education	16a. Deced	dent's Usual Occupa	tion	kina	16b. Kind of	Business/Ind	lustry
212	ithin 7 ie. ian "n	Completed	(Specify only highest Elementary/Secondary (0-12)	College (1-4or 5+	life. I	kind of work done done done done not use retired)	uring most or wor	Kiriy		TOME:	
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Ž	should nd Me mark matic	٩	19a. Informant's Name/Relationshi	p (Type. Print)	19b. Mailir	ng Address (Street a			er, City or Tow	n, State, Zip	Code)
<u></u>	nd 2 saith ar		LINDA ELLIS / 1	DAUGHTER	604	TROUT DAL	E TERRAC	E, BEL	AIR, M	ARYLAN	D 21014
ž,	ss 1 a of Hez		20a. Method of Disposition	O Domesial from State	20b. Place of Dispo		i	Date		n - City or To	
Ĕ	Page ment ant: If ant: If ury ol		1 → Burial 2 □ Cremation 4 □ Donation 5 □ Other (<i>Sp</i>		COKESB	URY CEMET	ERY 08	/18/08	ABING	DON, N	1ARYLAND
Baltimore,	permit. Departi Import any inj once,		21. Signature of Funeral Service L	icensee	1	2. Name and Addres LISA S	COTT FUN	VERAL HO	ME, P.	A.	MD 24.070
			23a. Part1. Enter the disease, or o	complications that caused	the death. Do not ent		WIS STR			JRACE,	MD 21078 Approximate Interval Between
	Physician	П	shock, or heart failure. List o Immediate Cause (Final disease or condition	nly one cause on each line	Liv	ur Car	car			د	Onset and Death
A	/Medical		resulting in death)	Due to (or as a	consequence of):						
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	ted Isit	njue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence or):						
,	icate be executed physician and the burial-transit	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence of):						
8/60	te be ysicial	dical		J		-21-					
0	rtifica ng ph	Medi	IF FEMALE:						1		
X R R	death certifi e attending d for use as	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome p 1 ☐ Live birth	2 ☐ Fetal death 3 ☐	Ectopic pregnancy				Date of delive Month	ery Day Year
- -	e law requires that the death certific has been signed by the attending p je 2 should be detached for use as	Physician/Me	1 ☐ Yes 2. No 9 ☐ Unknown	4□Pregnant at t 9□Unknown	time of death 5L	Other (specify)					
7.	requires that the een signed by the		Part II. Other significant condition	' s contributing to death bu	t not resulting in the u	nderlying cause give	n in Part I.	23e. Did to	obacco use co	ontribute to th	ne cause of death?
SD	quires n sign ald be	d by						1 🗆 1	res 2 No	3 ☐ Prob	ably 4 □Unknown
Hecords,	law rec as beel 2 shou	Completed						24a. Was		b. Were auto	psy findings available
	The la	mo.							rmed?	death?	inpletion of cause of 2 □ No
VITal	sician: Th certificate rector, pag	Be C	25. Was case referred to medical examiner?					th (Check only o			
0	hysik this co	2	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatier			4 □ Nursing H	ome 5 Resid			y)
	Jing F	ion:	27. Manner of Death 1 ★Natural 5 ☐ Pending investigation	28a. Date of Injur (Month, Day		Work	rat ? ∕es 2 ⊟ No	28d. Describe I	now injury occ	curred	
UIVISION	Attend death cctor: y the	Certification:	3 Suicide 6 Could no	ot be 28e. Place of inju	ry - At home, farm, str		2 2 110	28f. Location (5	Street and Nu	mber or Rum	d Route Number,
2	al or A after I Dire d in b	ertil	4 ☐ Homicide determin	building, etc	: (Specify)			City or Tov	vn, State)		
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	edical C		Physician: To the best of taxaminer: On the basis of and manner sta	examination and/or in						
	o the ithin 2 o the omple	Med	29b. Signature and title of certifier	and manner sta	ieu.	29c. License			29d. Date sig	ned (Month,	Day, Year)
)	⊢≤⊢ŏ		· ann/	in my)	73	5889		Ausu.	5+ 15,	2008
	~		30. Name and address of person v		eath (Item 23a) (Type,	Print)	- 1/-	0 1		// A >	1214
	0		31. Date filed (Month, Day, Year)	S PANUS 32 Registra	CIJ	Print) W. MACA	OBSIL	121,	AIN.	~1.12 J	1017
	Sta Registi		ALIG 1-8 200	18 Alexandre	r's Signature	V					

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			For State Registrar	State of Marylar		artment of F rtificate of			ene g. No2008	27905
	Physici	an	1. Decedent's Name (First, Middle, Las					2. Date of Death		3. Time of Death
	/Medio	al	LILLIAN C. 4a. Facility Name (If not institution, give	GREENWALD e street and number)		4b. City, Town, o	r Location of Death		4c. County of Dea	
			15100 Interlachen			Silver S			Montgo	
	Funeral Director		5. Social Security Number 6. S 109-14-1649 Usual Residence of Decedent	ex		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, May 4, 1	Year) 1926 Bro	rthplace (State or Foreign ountry) Onx, NY
	yland how		10a. State 10b. County		ty, Town or Lo					10d. Inside City Limits
	Ba-f sl	Director	Maryland Montgome	ery Sil	ver Sp					1 □Yes 2X No
	ath with the 23a or 2		10e. Street and Number 15100 Interlachen	Dr. #820		10f. Zip Code 20906			g. Citizen of What C	
21215-0036	should be filed within 72 hours after death with the Maryland of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show marked other than "section items 23a or 28a-f show marked other than "section in items 23a or 28a-f show marked other than 10 marked other than 10 marked other than 10 marked other	by Funeral	11. Marital Status 1 □ Never Married 2 → Married 3 □ Widowed 4 □ Divorced	12. Was Decedent Ever in U Armed Forces? 1 ∐Yes 2X No If Yes, Give Year or Dates:		Was Decedent of H fYes, specify Cuba 1 □Yes 2MMNo	dispanic Origin? (Span, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Am Black, Whi	
15-0	"natur	letec	15. Decedent's Ed (Specify only highest gra	de completed)	16a. Deced	dent's Usual Occup	oation during most of work d)	sing 10	6b. Kind of Business	s/Industry
212	filed withir Hygiene. Ither than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+) 1-4	1	ement Spe			lechinger	Co.
Baltimore, Maryland	be od o	To Be C	17. Father's Name (First, Middle, Last) Samuel Green:				18. Mother's Nam Margare	e (First, Middle, Ma t Ab	aiden Surname) oraham	
Jary	S E S E		19a. Informant's Name/Relationship (1			-	City or Town, State,	' '
re, l	0		Ernest Greenwald · 20a. Method of Disposition			Interlaction (Name of patory or other place			ver Spring Oc. Location - City of	g, Md. 20906 Town, State
imo	Pages ment of ant; If i ury or		1 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify					ig 13,08 (Olney, Ma	ryland
Balt	permit. Pages 1 an Department of Heal Important; If item 2 any injury or other once.		21. Signature of Funeral Service Licen	Bogward	← Do	Nama and Addre Onald V.	Borgward	t Funeral	Home, PA	20705
ı			23a. Part 1. Enter the disease, or companion, or heart failure. List only	plications that caused the deal one cause on each line.						Approximate Interval Between Onset and Death
-	Physician / /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Uterine C	lancer					
	Examiner		Sequentially list conditions	b						
B	cuted Id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underh in Cause (Disease or injury that initiated events	Due to (or as a consec	uence of):					
. 09289	rtificate be executed ng physician and as the burial-transit	sal Ex	resulting in death) Last	Due to (or as a consec	uence of):					
		Medical	IF FEMALE:	. u.					V ·	
O. Box	requires that the death cert een signed by the attendin hould be detached for use a	Completed by Physician/N	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ▼ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3	Ectopic pregnanc Other (specify) _	у		23d. Date of de Month	olivery Day Year
σ.	res that the de signed by the a be detached	by Ph	Part II. Other significant conditions co	ontributing to death but not res	ulting in the ur	nderlying cause giv	en in Part 1.			to the cause of death?
Corc		leted	NAME OF THE PROPERTY OF THE PR					1 ∐ Yes 24a. Was an	21	Probably 4 🗌 Unknown utopsy findings available
Division of Vital Records,	The a		25. Was case referred to medical					autopsy performe 1 □ Yes 2	prior to death? No 1 □ Ye	completion of cause of
f Vil	Physician: this certific ral director,	To Be	examiner? 1 ☐ Yes 2 🛣 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Oth		h <i>(Check only one)</i> ome 5 ∑ Residen	ce 6 ☐ Other (Sp.	ecify)
o uc	ling Pt 1. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury	28c. Injur Worl	y at k?	28d. Describe how		
ivisio	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Certification:	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	and the second s	ome, farm, stre		Yes 2 □ No	28f. Location (Stre City or Town,	eet and Number or F State)	Tural Route Number,
	e Hospital or a 24 hours after e Funeral Dire			ysician: To the best of my kno						
	To the H within 24 To the Fi complete	Medical	one)	iner: On the basis of examination and manner stated.	ation and/or inv					
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		29b. Signature and title of dertifier	MD		29c. Licens D 356			d. Date signed <i>(Mon</i> August 12,	
	1>		30. Name and address of person who o			Print)				
	Sta	0	Joseph Kaplin, MD 31. Date filed (Month, Day, Year)	18111 Prince		p Dr. # 3	32/ Olney	, Md 2083	32	
	Registr		AUG 15 200			A. 0				

State of Maryland / Department of Health and Mental Hygier 👂 🕦 💍 27906 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Roy Paul Hoffman T3, 2ďď8 August 6:20 p M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Ravenwood Lutheran Village Hagerstown Washington 5. Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 M 2 □ F Director 214-16-1917 88 July 9, 1920 Maryland Usual Residence of Decedent the Maryland 10a State 10b. County 10c. City, Town or Location 28e-f show 10d. Inside City Limits wat by notified at Director 1 ☐ Yes 2 ☐ No Maryland Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or Items 23e 1183 Luther Drive 21740 death U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 (★ es 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) traumatic event, the Medical Examiner: permit. Pages 1 and 2 should be filed within 72 hours atter to Department of Health and Mental Hygiene." naturalt, or tter Important: it item 27 is marked other than "naturalt, or tter may njury or other traumatic event, tre Madical Examples once. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) +3Clothier Retail 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Leidig Hoffman Althea Elizabeth Binkley 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bagley / Daughter Ann 5343 East Diamond Mesa Arizona 85206 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State * 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg Crematory 8/16/2008 Smithsburg Maryland 21. Signature of Funeral Sept ce Lionne e 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave. Hagerstown Maryland 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Coronny artin disease or condition resulting in death) Ibvech /Medical Due to (or as a contequence of) Examiner Karkinson 54 Lervs Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events) Examiner Due to (or as a consequence of) the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ţor in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. 1 ☐ Yes 2 ☐ No the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ director, page 2 should Be Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 1 ☐ Yes 2 TNo 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 | Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No Certification; To 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Magner of Death After ! 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide within 24 hours a To the Funeral C 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number 128365 1 au 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 10H 441 36 SHAM Strul Heigestermy nell 31. Date filed (Month, Day, Year) AUG 19 32. Registrar's Signature State 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Dav Year Boyden Hash /Medical 4:46 P August 1 2008 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery 5. Social Security Number 6. Sex If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthdav) **Funeral** 8. Date of Birth Birthplace (State or Foreign Country) 08 , 1Months Days Hours Min 13€ M 2 □ F 218-24-2473 77 July Director 1931 Maryland Usual Residence of Decedent 10a. State 10b. County show 10c. City. Town or Location 10d. Inside City Limits event, the Medical Exerciner must be notified Director 1 ☐ Yes 2X No MD Montgomery Germantown 28a-f 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a or 6 Metz Court 20874 death v Funeral United States items 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ es 2 ☐ No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours after 1 Never Married 2 Married 0, Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: Korea 1 ☐ Yes 2 TXNo Specify: ð Specify: White 3 Widowed 4 Divorced "natural" Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within than Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed witl Department of Health and Mental Hygiens Important: If item 27 is marked other tha any liqury or other traumatic event, I'm 1 one. 12 Bartender Private Club 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar J. Hash Lydia Hash Hash 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Beverly Hash (Wife) 6 Metz Court Germantown, MD 20874 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State August 15 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Metropolitan Crematory 2008 4 Donation 5 Dother (Specify) Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Drive Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Onset and Death Immediate Cause (Final **Physician** Hypoxia disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Shortness of Breath Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Chronic Heart Failure burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical Chronic Obstructive Pulmonary Disease the as the attending IF FEMALE for use yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 9 Unknown icate has been signed by , page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy certificate 2 X No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 \sum Nursing Home 5 \subseteq Residence 6 \subseteq Other (Specify) 1 ☐ Yes 2 🔀 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 28d. Describe how injury occurred 1 ANatural 5 ☐ Pending death. 2 Accident investigation 1 ☐ Yes 2 □ No 24 hours after death 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2 29b. Signature and title of gertifier 29c. License number My.)0065930 1 30. Name and andress of person who completed cause of death (Item 23a) (Type, Print) ano MA MEDICAM 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 15 Registrar AUG 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 13 Hale Ν. Lawrence A^{M} August 2008 9:05 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 788 Kimberly Court East Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs. Social Security Number 6. Şex 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Months Days Hours 1 X M 2 □ F 310-30-8307 74 June 23,1934 KY Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 X No Gaithersburg MDMontgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20878 United States 788 Kimberly Court East 12. Was Decedent Ever in U.S. Armed Forces? 1 ∑IYes 2 □ No Korean IfYes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 📉 No Specify: White Specify: 3 ₩ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Walter Reed Medical Elementary/Secondary (0-12) College (1-4or 5+) Medical Photographer Hospital 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alma Reed William Stanley Hale 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anthony L. Hale / Son 4621 Aaron Court, Jefferson, MD 21755 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State August 15 2008 Metropalitan Tematory 4 ☐ Donation 5 ☐ Other (Specify) Alexandria, Virginia 22. Name and Address of Facility DeVol Funeral Home, 10 East Gaithersburg, MD 20877 21. Signature of Funeral Service Licensee Deer Park Drive, 1RACO 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) METASTATIC PROSTATE ZYRS Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

"natural", or items 23a or 28a-f show

Director

Funeral

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Completed

Be

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Pages 1 and 2 should be filed within 72 hours after death with the Maryland

ind Mental Hygiene.

Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce.

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed burial-trar attending physician for use as the buria signed I certificate has been s rector, page 2 should director, funeral To the Hospital or Attending within 24 hours after death. To the Funeral Director; After

Division of Vital Records, P.O. Box 68760,

lical E)	resulting in death) Last	Due to (or as a conse	quence of):				
nysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 ☐ Live birth 2 ☐ Fet 4 ☐ Pregnant at time of 9 ☐ Unknown	tal death 3 Ectopic			23d. Date of delivery Month Day Ye	ear
eted by PI	Part II. Other significant conditions of	contributing to death but not re	sulting in the underlying	cause given in Part I.		use contribute to the cause of de No 3☐ Probably 4☐ Ur	
Сошріє					24a. Was an autopsy performed? 1 □Yes 2 🎛 No	24b. Were autopsy findings at prior to completion of caudeath? 1 □ Yes 2 □ No	vailable use of
e P	25. Was case referred to medical examiner?			26. Place of De	ath (Check only one)		
0	1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	□ ER/Outpatient 3 □ I	OOA Other: 4 In Nursing F	Home 5 K Residence	6 ☐ Other (Specify)	
ation:	27. Manner of Death 1 X Natural 5 ☐ Pending 2 ☐ Accident investigation		28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injur	y occurred	
Cerum	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined		nome, farm, street, factorify)	ory, office	28f. Location (Street an City or Town, State	nd Number or Rural Route Number)	er,
edical	29a. Certifier 1 ☐ Certifying Pr (Check only one) 2 ☐ Medical Exar	hysician: To the best of my kn miner: On the basis of examin and manner stated.	nowledge, death occurre nation and/or investigation	ed at the time, date and plac on, in my opinion, death occ	e, and due to the cause(s urred at the time, date and) and manner as stated. d place, and due to the cause(s)	

29c. License number

D0061083

29d. Date signed (Month, Day, Year)

August 13, 2008

31. Date filed (Month, Day, Year)

15

29b. Signature

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008



Paul Thambi, M.D., 9707 Medical Center Drive, #300, Rockville, MD 20850

Registrar

1. Decedent's Name (First, Middle, Last)

Physici /Medio		Booden's Name (1 list, Wilde	<u>Marjorie</u>	J Kirk				Month	Day	Year 2008	2:00 A M
Examir		4a. Facility Name (If not institutio				4b. City, Town, o	r Location of Dea			inty of Death	2:00 A ™
	1 4	Copper Ridge				Sykes			C	arroll	
Funeral Director		5. Social Security Number 217 03 0319	6. Sex 1 ☐ M 2 🙀 F	7. Age (In yrs. 89	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min	. (Month,	Birth Day, Year) 5, 1918	Coun	place (State or Foreign otry) yland
land ow		Usual Residence of Decedent 10a. State 10b. County		10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
Mary a-f sh fied a	tor	MD Carrol	.1	Sv	kesvil	le -					1 ☐ Yes 2 No
or 28:	Director	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun	itry?
s 23a nust b		710 Obrecht Roa			6	21748				ed Sta	
rs after de l', or item caminer r	by Funeral	Narital Status Never Married 2 Married 3 Widowed 4 Divorced	Armed F	2 X No live	1	Was Decedent of H f Yes, specify Cuba □ Yes 2 □X No	ispanic Origin? (: an, Mexican, Pue Specify:	Specify Yes or roto Rican, etc.)		Race - America Black, White, o	
2 hou ratura ical E		15. Deceden	it's Education		16a. Deced	lent's Usual Occup	ation		16b. Kind of	f Business/Inc	
d within 7 giene. r than "n the Medi	Completed	(Specify only higher Elementary/Secondary (0-12)	st grade completed College	(1-4or 5+)	(Give life. E	kind of work done of 00 NOT use retired Homemaker	during most of wo l)	orking		n Home	idotty
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be C	17. Father's Name (First, Middle, Earl E. Wantz	Last)					me (First, Midd	lle, Maiden Surr		
2 shou and N Is mai		19a. Informant's Name/Relations	hip (Type. Print)		19b. Mailin	g Address (Street	and Number or R	tural Route Nun	nber, City or Tov	vn, State, Zip	Code)
l and fealth im 27 her tr		Donald H. Kirk,	Jr./Son		3745	Dorsey S	earch Ci	ircle E	llicott	City,	MD 21042
bages ent of Hert. If ite		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 🙀 Other (S	3 □Removal from		riace of Dispos cemetery, cren	sition (Name of natory or other plac	e)	Date	20c. Locatio	on - City or To	wn, State
permit. F Departm Importar any injur		21. Signature of Funeral Service	Licensee 11	M01		Name and Addres	4 E	22-2008 arry H		more, N	ily FH Inc
205 # 9		Dow Gilla	100		4	112 Old C	olumbia	Pike E	llicott		MD 21043
Dharistan		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on	^ -	1	er the mode of dying	g, such as cardia	c or respiratory	arrest,		Approximate Interval Between Qnset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to	Of as a consequence							Years
Examiner		Sequentially list conditions.	b								
ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events	Due to	(or as a consequ	uence of):						
be executed sician and burial-transit	Exar	that initiated events resulting in death) Last	c Due to	(or as a consequ	uence of):						
death certificate be executed e aftending physician and d for use as the burial-transii	lical		d								
certific iding p	/Mec	IF FEMALE:	23c If yes ou	itcome pf pregna	ncv						
	/sician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1 □Live	birth 2 🗍 Fetal nant at time of de	Ideath 3	Ectopic pregnancy Other (s <i>pecify</i>)				Date of deliver Month	ry Day Year
The law requires that the de te has been signed by the a page 2 should be detached	/ Phys	Part II. Other significant condition	ns contributing to d	leath but not resu	ulting in the un	derlying cause give	n in Part I.	23e. Dic	I tobacco use co	ontribute to th	e cause of death?
igi res	0										ably 4XUnknown
law re as bec 2 sho	Completed							24a. Wa		b. Were autor	osy findings available
	Com							aut per 1□ Yes	opsy formed? 2 X No	death?	npletion of cause of 2 ☐ No
sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Otho	26. Place of Dea	ath (Check only			
ding Phys h. After this funeral dii	2	1 ☐ Yes 2X No 27. Manner of Death	28a. Date	of Injury	ER/Outpatient 28b. Time of		4 № Nursing F		sidence 6 C)
ending P tath. or; After I he funera	atio	1X Natural 5 ☐ Pending investig	ation	nth, Day Year)	Injury	28c. Injury Work M 1 ☐ Y	? ′es 2		non mjary coo	urrod	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could n 4 ☐ Homicide determi	ned 28e. Place	e of injury - At ho ing, etc. (Specify	me, farm, stre	et, factory, office		28f. Location City or To	(Street and Nur. own, State)	nber or Rural	Route Number,
lospita I hours uneral		29a. Certifier 1 XCertifyIn	g Physician: To the Examiner: On the b	best of my know	vledge, death	occurred at the tim	e, date and place	e, and due to th	e cause(s) and i	manner as sta	ated.
thin 24	Medical	one) 29b. Signature and title of certifier	and man	ner stated.		29c. License		urred at the time			
F 3 F 8		► 1/11 U	- M/	\sim		1			29d. Date sign		
2	-	30. Name and address of person v			23a) (Type, P	rint)	5813-		Augu	ıst 18,	2006
		W. by Kus 31. Date filed (Month, Day, Year)	295 5	to ne/	Avo S.	+307 1	Westnin	ster	MD 2	115	7
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Date of Death Month

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Oroth 2:00 P.M 2008 August 10, 4a. Facility Name (If not institution, dive street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Montgomery General Hospital 01ney If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Feb. 9, 9. Birthplace (State or Foreign Country) New Jersey 1 □ M 2 T F Year, 83 Yrs. Feb. 1925 152-12-1499 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 √Yes 2 No Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2806 Clear Shot Drive, # 20906 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ※☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛛 No Specify: Specify. 3 ☐ Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Hair Salon Receptionist 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Surname) Morris Cowell Lillian Kaufman 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jody Goldkind - Daughter Wickham Road, Olney, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Judean Mem. Gardens 8/13/2008 Olney, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Edward Sagel Funeral Direction, Inc. Oonald. 1091 Rockville Pike, Rockville, Maryland 20852 23a. Part 1. Enter the disease, or complications that caused the leath. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ardio (041) Due to (or as a consequence of Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown 9 Unknown

Physician /Medical Examiner

The law requires that the death certificate be executed

the

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certificate

Box 68760,

P.0.

Division of Vital Records,

Physician

Examiner

Funeral

Director

filed within 72 hours after death with

2 should be fi and Mental H

Department of Health and Important: If Item 27 is many Injury or any

Baltimore, Maryland 21215-0036

/Medical

10a. State

Director

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Completed

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Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner physician and the burial-transit

Physician/Medical attending ph signed by the a þ Completed page 2 To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be Certification: To

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🗆 No

25. Was case referred to medical examiner? 1□Yes 2√□No

2 Accident

(Check only one)

31. Date filed (Month, Day,

AUG

26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

27. Manner of Death 1 Natural 5 Pending investigation

28a. Date of Injury (Month, Day, Year)

28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

29b. Signature and title of certifier

29c. License number

29d. Date signed (Month, Day, Year)

Year)

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28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1201 Seven Locks Road, #200 Rockville, MD 20854 Aruna Paspula, MD

State Registrar

Medical

Registrar's Signature

als

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav **Physician** Year Daniel 12:15 P^M Joseph Kelliher August 12 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5104 Durham Road W. Columbia Howard If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 XM 2 □ F 578-50-2828 69 **Director** Oct. 19, 1938 Wash. D.C. Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits an "natural", or Items 23a or 28a-f show Medical Examiner must be notified at 1 K∆Yes 2 No Director Columbia Maryland Howard 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 5104 Durham Road W. 21044 permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23s any injury or other traumatic event, the Medical Exa<u>miner must.</u> USA Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Yes 2 No If Yes, Give 1960 Year or Dates: 1960 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: þ 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Insurance Company Insurance Broker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Daniel D. Kelliher Mary Ellen Morley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jacqueline Kelliher/Wife 5104 Durham Rd., W., Columbia, Md. 21044 20b. Place of Disposition (Name of cemetery, crematory or other p Gate of Heaven Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) Aug.18,08 21. Signature of Veral Service I 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., NW Wash., D.C. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Acute **Physician** Myeloid leukemia year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine burial-tra Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome pf pregnancy
1 □ Live birth 2 □ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an autopsy performe 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No neral Director: /

The law requires that the death certificate be executed and Division or Vital Records, P.O. Box 68760, attending physician for use as the buria page 2 s has certificate o the Hospital or Attending Physician: - othe Hospital or Attending Physician: this

After

the Funeral within 24 hours

2

10

show

Baltimore, Maryland 21215-0036

1 Natural 2 ☐ Accident

3 Suicide 4 ☐ Homicide

29a. Certifier (Check only

6 ☐ Could not be

and manner stated.

Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

— edical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

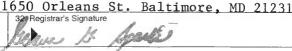
29b. Signature and title of certifier R

29d. Date signed (Month, Day, Year) August 13 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Mark Levis, MDYear) 31. Date filed (Month, Day, State

15 2008 AUG



Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar/MEND#7perFH8/15/08, BMW, McCo 27912 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Month Year Nam Saeng 2:33 AM 8 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Mayland Baltimore Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 9. Birthplace (State or Foreign **Funeral** 1**X** M 2□ F Months Days Hours 213-11-1358 Aug. 14,1959 South Korea Director Usual Residence of Decedent 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10d. Inside City Limits MD. Montgomery Potomac Director 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13101 Brushwood Way 20854 South Korea Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 1 Never Married 2 Married 2XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 Widowed 4 Divorced Asian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Contractor Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Hyoung Do Kim Young Ja Cho 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (Wife) 13101 Brushwood Way, Potomac, MD 20854 Jung Hie Kim 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State August 4 ☐ Donation 5 ☐ Other (Specify) Norbeck Memorial Park 2008 Olney, Maryland 21. Signature of Funeral 22. Name and Address of Facility DeVol Funeral Home, 10 E. Deer Park Drive, Gaithersburg, MD 20877 23a. Part1 Enter the diseas ease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ire. List only one cause on each line. Approximate Interval Between Onset and Death Imme that Cause (Final disease or condition resulting in death) **Physician** Severe Heidosis Several Hours /Medical Due to (or as a consequence of): Examiner Shock Several Hours Sequentially list conditions, if any, leading to immediate cause. Disease or injury that initiated events resulting in death) Last Due o (or as a consequence of) that the death certificate be executed Several Hours and Due to (or as a consequence of) Box 68760, physician Aspiration Physician/Medical 6-8 Hours the attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, Completed by Dystipidemia 2 No 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑No page 2 s 24a. Was an autopsy performed? Yes 2/11 No certificate Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 10 1 Impatient 1 Yes 2 ER/Outpatient 3 DOA မှ 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending the Funeral Director: After whetely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🕍 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mapner stated. To the within 2
To the complet 29b. Signature and 29c. License number 29d. Date signed (Month, Day, Year) 22182 812108 00 18253 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Lindstrom

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2008

31. Date filed (Month, Day, Year)

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22 S., 32 Registrar's Signature Street, Baltimore, MD

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			Registrar	/F1 + 1514 H			Ce	rtificate of	Death	ל		Reg.	No.	,
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	Funeral		Social Security N		6. Sex	7. Age (In)	yrs. last birthday)	If Under 1 Year	If Unde	er 24 Hrs.	8. Date of B			irthplace (State or Foreign
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	hours after death with the Maryland tural", or items 23a or 28a-f show al Examination must be notified at	Funeral	11. Marital Status		12. Was Dece	edent Ever in	n U.S. 13.	Was Decedent of I		Origin? (Sp	ecify Yes or N	lo-	14. Race - Ar	nerican Indian,
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2	filed Il Hyg other	Be C	17. Father's Name	(First, Middle, L	ast)		1100	<u> </u>	18. Moti	her's Name	e (First, Middle	_		
7	uld be Ments Ments rked tic ev	To E	Low Gi	ng					Ma	rie	Ling			
Baltimore. Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination in the notified at once.		19a. Informant's Na					ng Address (Street						
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N	execu	Examiner	that initiated events resulting in death) I	Last	c Due to	(or as a cons	sequence of):							
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18 J	that the		Part II. Other signif		! is contributing to de	eath but not r	resulting in the u	nderlying cause oi	on in Part	. j	23e Did	tobacc	n use contribute	to the cause of death?
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_	spita hours neral y fillec		29a. Certifier	1 Certifying	Physician: To the	best of my i	knowledge, deatl	n occurred at the ti	me, date a	and place,	and due to the	e cause	e(s) and manner	as stated.
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	ledical	(Check only one)	2 Medical E	kaminer: On the b	asis of exam ner stated.	ination and/or in	vestigation, in my	opinion, de	eath occur	red at the time	, date	and place, and d	ue to the cause(s)
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amend #10a-c Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. 2008 27914 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Day **Physician** August 11, 2008 Philip Levin 1:50 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 7420 Westlake Terrace, #604 Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1**X** M 2□ F Hours Min Director 068-05-3564 92 May 9, 1916 New York Usual Residence of Decedent the Maryland 10a State 10bBroward 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinational to notified at MD FL Director 1X Yes 2 No Montgomery Bethesda Pompano Beach 10e. Street and Number 821 Cypress Blvd, #304 10f. Zip Code 10g. Citizen of What Country? death with 20817 33069 7420 Westlake Terrace, #604 IISA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status be filed within 72 hours after 1 Never Married 2 Married Saltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐ Yes 2 📉 No Specify. ð Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 7 th and Mental Hygiene. 7 Is marked other than "r Elementary/Secondary (0-12) College (1-4or 5+ 5+ Executive Wholesale Drugs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gussie Fastov Jacob Levine ဂ္ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 Is n any Injury or other traun once. Selma_Levin-Wife 7420 Westlake Terrace,#604 Bethesda, MD 20817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 8/13/2008 4 Donation 5 Dother (Specify) Judean Mem. Gdns. Olney, MD 22. Name and Address of Facility Edward Sagel Funeral Direction Inc. 1091 Rockville Pike Rockville, MD 20852 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Irreversible Dementia 6 Months disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Parkinson's Disease 5 Years Sequentially list conditions, lary leading the conditions, cause. Enter Underlying Cause (Disease or injury that initiated events ner Due to (or as a nonsequence of) The law requires that the death certificate be executed Exami physician and s the burial-trans resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical as attending properties as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) P.0. s been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy certificate perform 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of After t 28c. Injury at Work? 28d. Describe how injury occurred Hospital or Attending 5 ☐ Pending investigation 1 Natural the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifiei Medical completely (Check only one) To the within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 10 Mus August 12, 2008 nun D23392 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James F. Wilson, MD 10400 Connecticut Avenue, #606 Kensington, MD 20895 31. Date filed (Month, Day, Year) 32/Registrar's Signature State 15 AUG Registrar 2008

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 1 1Day2008 Year August Physician Jane Ritchie Larson /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Montgomery Bethesda Maplewood If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 06-2-1922 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min California 1 ☐ M 2 🖾 F 86 **Director** 091-20-1560 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County d other than "natural", or items 23a or 28a-f show event, the Madical Evanding Coast by notified at 1 ☐ Yes 2 No Bethesda MD Montgomery Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with United States 20817 9707 Old Georgetown Rd #1420 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 21 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐Yes 2X No <u>}</u> 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene Important: If Item 27 is marked other that any injury or other traumatic event, Item 2000. Ceramics 5+ Artist 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Viola Lockhart Stafford Warren ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13771 Mercado Sr., Del Mar, California 92014 Larry Lawson/Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 8-13-08 Falls Church, VA National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service I 5130 Wisconsin Ave, N.W. Washington DC 20016 Will. Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that dused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Cerebral Vascular Accident resulting in death) /Medical Due to (or as a consequence of): Examiner Atrial Fibrallation Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Division of Vital Records, P.O. Box 68760, (Hospital or Attending Physician: The law requires that the death certificate be executed physician and the burial-transit Coronary Heart Disease Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) been signed by the should be detached 9 Tilnknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2X No 3 ☐ Probably 4 ☐ Unknown Diabetes Mellitus 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an r this certificate has b graf director, page 2 st Hypertention autopsy performed? yes 綦□No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28h Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: After 1 Natural 5 Pending investigation after death.

Director: Af d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide within 24 hours aft

To the Funeral Di

completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Umbedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier August 11, 2008 D35791 30. Name and address of person who completed cause of death (Item 234) Type, Frint) MD 9801 Silver Spring, Maryland 20902 Merlyn Vemury, Georgia Ave., 31. Date filed (Month, Day, 32 Registrar's Signature Year) State 5 AUG Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Mills DeLanta J. 1357 19,2008 August 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis If Under 1 Year | If Under 24 Hrs. Anne Arundel 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) Hours Months Days 1 **3** M 2 □ F 219-28-3132 23,1933 Maryland May Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 XYes 2 No Md. PG Bowie 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 20715 13215 10th Street United States 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 X Yes 2 ☐ If Yes, Give Year or Dates: 1 ☐ Never Married 2 🔀 Married 2 No 1 ☐ Yes 2 🗓 No 956 Specify. Specify:Black 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) PG County Schools Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) McCager Mills Jessie Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13215 10th Street Bowie, Md. 20715 19a. Informant's Name/Relationship (Type. Print) Alice Mills/wife Bowie, Md 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Veterans Cem. 8/29/08 Cheltenham, Md. 2. Name and Address of Facility Hodges & Edwards F.H. 21. Signatury of Funeral Service Licensee 3910 Silver Hill Rd., Suitland,Md.20746 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) as a conseque remsoleral1 if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events and the cause of the c resulting in death) Last Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ binknown 24b. Were autopsy findings available prior to completion of cause of death? 1 □Yes 2□No 24a. Was an autopsy performed 1∐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 Yes 2 No 2 ☐ Accident

Physician /Medical Examiner

Examiner

Physician/Medical

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/Medical

Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

3altimore, Maryland 21215-0036

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P.O. Box 68760,

Division or Vital Records,

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within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral

To the Hospital o within 24 hours aft To the Funeral DI

State Registrar 29b. Signature and title of certifier

and manner stated.

6 ☐ Could not be

29c. License number

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Wood

2001 median

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

31. Date filed (Month, Day, AUG 2 9 (Month, Day, Year) 2008

3 ☐ Suicide

29a. Certifier

im

4 Homicide

32. Registrar's Signature Boules Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

		_1	1 - For State Registrar amend #1 Per Phy G883 9/24	708 JH Certificate of L		Reg. N	2008	27917 3. Time of Death
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	ns 23	Funeral	5710 Ripley Park Drive 11. Marital Status 12. Was Decedent Ever in U.S.	13. Was Decedent of Hi If Yes, specify Cuba		y Yes or No-	14. Race - Ame Black, White	rican Indian,
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Maryland 21215-0036	should be and Mental s marked o	욘		9b. Mailing Address (Street a				Zip Code)
<u> </u>	od 2 s ith ar 27 is rtrau		Amy Sexton/Daughter 5	710 Ripley	Park Dri	ve La E	lata,M	20646
ā,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Deparment of Heath and Mental Hygiene. Importanent of Heath and Mental Hygiene. Important: It item 27 is marked other than "natural" or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 20b. Place	of Disposition (Name of etery, crematory or other place	Dat	e 20c.	Location - City or	
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ec	as b	Completed	Respiratory Failure Curric	COITA TIAL	260 3 10 WG	24a. Was an autopsy performed	prior to	utopsy findings available completion of cause of
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	12		30. Name and address of person who completed ceuse of death (Item 23)	MD _ 22	SOUTH G	REENE	57 K	PARTIMORE
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	ems 2	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U.S.	13. Wa	s Decedent of H	lispanic Origin? (Sp an, Mexican, Puert	pecify Yes or No Rican, etc.)	0-	14. Race - Ame Black, White	
21215-0036	should be filed within 72 hours after death with the Maryland of Mentai Hygene. marked other than "natural", or items 23a or 28a-f show marked other than "natural", or items 23b or 28a-f show matic event, the Medical Examiner must be notified at	ğ	1 ☐ Never Married 2☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:			Yes X∏ No	Specify:			Specify: Wh:	
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Baltimore,	permit. Pages of Department of Important: If Ite any Injury or of Once.		21. Signature of Funeral Service Lice		DIII T L I			ndCem.				Chapel, P. A
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			23a. Part1. Enter the disease, or com shock, or heart failure. List only	ations that caused to one cause on each line	he death. D	o not enter	the mode of dyir	ng, such as cardiac	or respiratory	arrest,		Approximate Interval Between Onset and Death
V.	Physician		Immediate Cause (Final disease or condition resulting in death)	a. End - 3			emen	tra				Onset and Death
	/Medical Examiner			Due to (or as a	consequenc	ce of):						
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ρ.	executed n and ial-transit	Examiner	Cause (Disease or injury that initiated events	c								
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Y Y	The lay te has age 2	Completed by							auto	opsy formed?	death?	utopsy findings available completion of cause of
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Division or	ng I	ion:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day		b. Time of Injury	28c. Inju Wo M 1	ryat rk?]Yes 2∐No	28d. Describe	how in	jury occurred	
<u> </u>	or Attendi after death. Director: A in by the fu	ficat	2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of injur	y - At home,	farm, stree		1163 2 1160	28f. Location	(Street	and Number or R	ural Route Number,
	al or safter	Certification:	4 ☐ Homicide determined	building, etc.	(Specify)				City or To	own, Sta	ite)	
	To the Hospital or Attu within 24 hours after de To the Funeral Directo completely filled in by the	edical (29a. Certifier 1 ☐ Certifying Pl	hysician: To the best of miner: On the basis of	my knowled	dge, death of and/or inve	occurred at the ti	ime, date and place	e, and due to thurred at the time	e cause	(s) and manner a	s stated. e to the cause(s)
	thin 2,	Med	one) 29b. Signature and title of certifier	and manner state	ed.		29c. Licens	se number		29d. D	Date signed (Mon	th. Day. Year)
)	F B F 8		100	B D					į	2	12110	8
•	lo		30. Name and address of person who	completed cause of dea	ath (Item 23a	a) (Type, Pr	int)	F J / +-			, ,,	
	W		30. Name and address of person who Deneen Bowlin	, MD 711	Maria	den	Choic	e Lave	Cato	nev	ille, w	10 21228
	Sta Registr		31. Date filed (Month, Day, rear)	32. Hegistiai	's Signature	baste	,		4			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State Registra MEND#10a+c, 12, 20aperFH, 8-15-08, EMW, Great ificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** MENDELSOHN 2:10 A-M 2008 /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Montgomery Hebrew Home of Greater Washington Rockville 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Feb. 12, 1930 Months Days Hours 1 □ M 2 X F Newark, NJ 150-22-1502 78 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 1 X Yes 2 ☐ No Director Washington, DG D.C. 10g. Citizen of What Country? 10e. Street and Number U.S.A. 20015 6117 32nd. St. NW Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1∆ Yes 2 ☐ No If Yes, Give Year or Dates:Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No White Specify: Completed by 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Retail Sales Sales Person 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Hellman Robert Charles Mendelsohn Rosalind 19b. Mailing Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 6117 32nd. St. NW Washington, DC 20015 19a. Informant's Name/Relationship (Type. Print) Jill M. Phillips - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 □ Cremation 3 X Removal from State Aug. 17, 2008 Union, NJ B'Nai Abraham Cem. 4 □ Donation 5 □ Other (Specify) Donald V. Borgwardt Funeral Home, PA 4400 Powder MIII Rd. Beltsville, Md 20705 21. Signature of Funeral Service License 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final KIDNEY DISEASE **Physician** STAGE END disease or condition resulting in death) /Medical Due to (or as a consequence of) YEARS Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. attending physician and for use as the burial-tran Due to (or as a consequence of) Records, P.O. Box 68760, 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 ☐ Other (specify) I ☐ Yes 2 ☐ No 9□Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by DEMENT 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Ame Koran, MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6121 MONTROSE RD ROCKVILLE MD 20852 ANNA KORZAN 32. egistrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 110 0755M the 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death Examiner KICOMICO 5445641 Keg IONAL If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) Age (In vrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** 1 M 2 □ F Months Days Hours Min -68-966 Director Usual Residence of Decedent 06/12/1958 MD with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show Department of Health and Mental Hygiene. important: If them 27 is marked other than "natural", or items 23a or 28a-f show in Injury or other traumatic event, the Medical Examination in in Injury or other traumatic event, the Medical Examinations. 1 Ves 2 No Director MY 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? .S.A 126 Chesapeake 2181 Funeral death v 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: Specify. 2 Specify: Black 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Police Department Chie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Olan Othello Morgan ပ Leola TUIL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Crisfield MD 31817 Morgan Denise 126 Chesapeake Ave. altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Pages 1 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 8 1608 Family Lawsonia MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 917 W. Isabella St salisbury, MD21801 Bennie Smith Funeral Itome implications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, only one cause on each line. Part I Enter the disease shock or heart failure Approximate Interval Between Onset and Death immediate Cause (F) Physician Shoch disease or condition resulting in description /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine be executed burial-tran and Due to (or as a consequence of) P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day 5 Other (specify) cate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 ☐ Yes VINo 1 □ Yes 20 NO e Hospital or Attending Physician: 24 hours after death.
Funeral Director: After this certifice funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1□ Yes & No Inpatient Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation filled in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical (Check only one) within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OGESIA VOHLA 614 SAUSBURY EASTERN

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

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32. Raistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] § 27921 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month Physician 22 12:50 A Frances W. Owens Aug. 2008 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 2527 Harkins Road Harford White Hall If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 X F Mar. 9, 1911 97 212-30-5731 MD Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show item 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Michigal Examinal must be truthlied at 1 ☐ Yes 21 No Director Harford MD White Hall 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number with 21161 USA death Completed by Funeral 2527 Harkins Road 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify 3 ☑ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) filed withi Hygiene Paper Supply Secretary 10 permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If Item 27 Is marked othany injury or othar traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert Schweizer Wilhelmina Engelmeyer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Joseph F. Owens Son 2527 Harkins Road White Hall, MD 21161 Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Most Holy Redeemer Cemetery Aug. 25, 2008 Balto., MD 21206
22. Name and Address of Polity J. J. Hartenstein Mortuary, Inc. 21. Signature / Eun rel Service Licensee tech 19 South Main St. Stewartstown, PA 17363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** YPANS /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 Tyes 2 10 3 Probably 4 Unknown Dm Be Completed been s 24b. Were autopsy findings available prior to completion of cause of death? CHE 24a. Was an has autopsy performed' Bludder Canar 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 1 ☐ Yes 2 ☐ No 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To this 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After or Attending 1 Matural 5 Pending death. 1 Yes 2 No investigation 2 Accident after death the 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D31295 23/08 30. Name and address of person who com reted cause of death (Item 23a) (Type, Print) Kiresz 5701 Baldmore Kenwoud MD 21206

Registrar DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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2008

32. Registrar's Signature

Division of Vital Records. P.O. Box 68760.

Baltimore, Maryland 21215-0036

			For State of Maryland / Dep	artment of Health and N <i>rtificate of Death</i>	lental Hy	giene Reg. No. 2	008	27922
₹)			Registrar 1. Decedent's Name (First, Middle, Last)	Timodio or Dealit	2. Date of De	ath		3. Time of Death
	Physicia	_	Molly A Olbrich		Month 08	Day 10	Year 2008	04:45 M
	/Medic Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. Cour	ty of Death	
			University of Maryland MC	Baltimore				
8	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday	If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	8. Date of Bir (Month, Da	ıy, Year)		place (State or Foreign ntry)
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	land ow		10a. State 10b. County 10c. City, Town or L	ocation			1	0d. Inside City Limits
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	or 282)ire	10e. Street and Number	10f. Zip Code		10g. Citizen o	f What Cour	ntry?
	23a ust b	Funeral Director	228 Olde Point Lane	21658		United		
	tems	une	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No Rican, etc.))- 14. H	ace - Americ lack, White,	
9	hours after death with the Maryland tural", or items 23a or 28a-f show al Examiner must be notified at	by F	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 3 Widowed 4 Divorced Year or Dates:	1 ☐ Yes 2XI No Specify:		Spec	oify: W	Thite
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7	d with	E OC		ers and Aquisition		Bank.		
	be file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last) George Patrick	18. Mother's Nam Marie T	' '	, Maiden Surn	ame)	
<u>X</u>	2 should be filed within 7 and Mental Hygiene. Is marked other than "r aumatic event, the Med	2		ing Address (Street and Number or Ru.		or City or Toy	un Stata Zir	2 Codol
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ย์	Heal Heal tem 2		20a Method of Disposition 20b. Place of Disp		Date	20c. Locatio		
ē	ages ent of ht: If I		11 ABurial 2 iCremation 3 IHemoval from State	rs Cemetary 2008	st 13,	Queen	stown,	Maryland
saltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	. 23		22. Name and Address of Facility Fellows Helfenbein		wnam Fi	neral	Home, P.A.
מ	Per Imi		Chad Helienbein per DVR	106 Shamrock Road.	Cheste	r, Mar		
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.	nter the mode of dying, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
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	ding Ph h. After th funeral	ion	1 □ Natural 5 □ Pending (Month, Day Year) Injury	Work? M 1 ☐ Yes 2 ☑ No		Tion injury oo	001100	
DIVISION	Attendiction of the	fical	3 Suicide 6 Could not be determined 28e. Place of injury - At home, farm, s	OMU	Fall 28f. Location	(Street and Nu	ımber or Ru	ral Route Number,
S	pltal or At ours after d leral Direc filled in by	Certification:	4 Homicide determined building, etc. (Specify) Home			own, State) Point	Lane,	Queenstown
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifler (Check only (Check only Medical Examiner: On the basis of examination and/or	ath occurred at the time, date and place	e, and due to the	e cause(s) and	manner as	stated. to the cause(s)
	To the Hosp within 24 hou To the Fune completely fi	edical	one) and manner stated.					
	To with	Σ	29b. Signature and title of certifier	29c. License number		29d. Date sig		
	1000		The state of the s	17518		0/	13/4	2008
	IND		30. Name and address of person who completed cause of death (Item 23a) (Type			/	/	
	Sta	te		imore MD 21224				
	Registi	ar	AUG 1 8 2008 Brane B	ne of				

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Ella Louise Patchell 2008 09:25 /Medical August 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner E1kton 1 Year | If Under 24 Hrs. Union Hospital of Cecil County Cecil 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2XX Months Days Hours Min Director 220-62-0058 Maryland 86 June 7, 1922 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show nit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla artment of Health and Mental Hygene. ortant: If frem 271s marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at injury or other traumatic event, the Medical Examiner must be notified at 1 Tyres 2 □ No Director Maryland Ceci1 Charlestown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 332 Caroline Street 21914 United States Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2 YNO
If Yes, Give
Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes ATTNo Specify Specify: Completed by White 3 ₩idowed 4 Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ۵ George Clifton Gibson Phoebe Walker . c, Mc.
...-rmit. Pages 1 and 2 sho.
Department of Health and M.
Important: If item 27 ie
any Injury or o** 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LuAnn Hall / Daughter 98 Solanco Road, Quarryville, Pennsylvania 17566 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State August 16 1 Bunal 2 Cremation 3 R 4 Donation 5 Other (Specify) 3 Removal from State Mayerdale Crematory 2008 Newark, Delaware 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Crouch Funeral Home 127 South Main Street, North East, Maryland21901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician MONOY pron disease or condition resulting in death) /Medical Due to (pr as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner onsequence of) law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Day 4□Pregnant at time of death 5 Other (specify) P.0. ed by the a detached f 9 Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 25 No 2 1 ☐ Yes 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Medical Certification: 5 ☐ Pending investigation Year) (Month, Day Injury 1 Natural 1 Yes 2 No 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 0 Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) the 29b. Signature and little of certifier 29c. License number 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

Registrar AUG 1, 8 2008

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August 12 Day 2008 Year Louise Sivills Persinger 03:45 A M /Medical 4a. Facility Name (If not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Spa Creek Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day) Birthplace (State or Foreign Country) **Funeral** Vear 1 □ M 2 □ XF Director 245-16-3156 87 07/03/1921 North Carolina Usual Residence of Decedent with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Maryland Anne Arundel Director Annapolis 1 ☐ Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 'natural', or Items 23a 2554 Carrollton Road 21403 United States Funeral filed within 72 hours after death Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hygien Important: If item 27 is marked othar the any injury or other traumatic event. Leagure. Bookkeeper Law Firm 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Thomas Sivills Elizabeth Dryden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Bonnie L. Persinger/Daughter 2554 Carrollton Road, Annapolis, Maryland 21403 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Kalas Crematory 08/12/2008 Edgewater, Maryland ^¹ 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** org. /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Little underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical attending p for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Tyes 2 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? 2 0 No 1 Yes 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical 26. Place of Death Check onl one examiner 1 Yes 2 No Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Certification: 28d. Describe how injury occurred After 5 Pending death. 1 ☐ Yes 2 ☐ No after death 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 24 hours at 29a. Certifier recertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OC 31. Date filed (Month, Day, Year) AUG 1 4 2008 gistrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Williams WINTON DRAINE 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** WIMICO 54415641 PAIONAL If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Social Security Number **Funeral** Year) Days Hours Months 1 M 2 KF Yrs. - 1925 MARYLAND 7594 Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Exporter must be notified at 1 ☐ Yes 2 No Director MARYLAND SOURU Wicomico 10g. Citizen of What Country? 10e. Street and Number 10f. Zp Code Rond USA 71801 LAS. 816 by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Thinks 1 □Yes 2 No Baltimore, Maryland 21215-0036 Specify. Specify: Black 3 Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NONE Domestic 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Williams Elizabeth 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) md 21801 Williams AUE. Richard SON N. DELAND 1012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Springfill CEMETERN HEDRON, 8 16-08 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of acility Stewar SEWAR! HOME FUNERA 821 Approximate Interval Between 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) End **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-tran Due to (or as a consequence of) Box 68760, Physician/Medical as IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) P.0. 9 🗌 Unknown icate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be determined 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 63199 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. SALISBURY EASTERN 614 SHORE VOITRA 31. Date filed (MontAUG Year) 5 2008 istrar's Signature State

DHMH 17 Rev 1/2001

Registrar

24-16-7594

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Martin Allen Richardson State of Maryland / Department of Health and Mental Hygiene 2008 27926 1- For State Certificate of Death Reg. No Registrar . Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death 3. Time of Death Month August 22, 2008 Medical Examiner 1130 hrs Martin Allen <u>Richardson</u> 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Mount Airy 201 Watersville Road Carroll 5. Social Security Number **Funeral** 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months oreign Days Hours Director May 26, 1936 232-50-7345 1X M 2 F Country\\\ 72 Yrs. Usual Residence of Decedent any 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Mt. Airy MD Carroll 28a-f show 1 x Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 201 Watersville Road Apt. 18 21771 USA with the Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or Nomust be 1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Yes 9 Specify: white Widowed Yes, Give Yea hours after Divorce Yes 2 X No specify: à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77. Department of Health and Mental Hygeiene. Important: If item 27 is marked other than 12 laborer Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E.C. Richardson Ruth Abbott Richardson Be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cheryl Cannon daughter HC 86 Box 301 WV 26722 Greenspring 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State crematory or other place) 8/24/2008 MD Cresaptown Scarpelli Funeral Home, P.A Donation 5 Other Specify 21. Signature of Funeral Service Cia 22. Name and Address of Facility Scarpelli Funeral Home, PA 23a. Part I. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Approximate Interval Between Onset and /Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death)' Last The law requires that the death certificate be execu Physician/Medical the attending physician ed for use as the burial UNPENDED AMENDED Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Day Year past 12 months Pregnant at time of death Other (Specify 1 Yes 2 No 9 Unknown been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? è Yes 2 No 3 Probably 4 ✔ Unknown chronic alcohol abuse Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? ✓ Yes 2 1 🗸 To the Hospital or Attending Physician; within 24 hours after death.

To the Funeral Director: After this conits. this certifi 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Other₄ Inpatient 2 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene 1 V Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 V Natural I Director: Pending Yes 2 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E August 23, 2008 30. Name and address of person who completed cause of death (Item 23a) Pamela E. Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registra DHMH 17 Rev 1/2001

OCME 2006

31. Date filed (Month, Day, Year)

32. Registrar's Signature

			. For	State of M						-	giene		27027
			1 - State Registrar			Cei	rtificate	of Dea	th		Reg. No.	UB	21921
	Physicia		 Decedent's Name (First, Mid- John Jerome 	_						2. Date of De Month	eath Day	Year	3. Time of Death
	/Medic Examin		4a. Facility Name (If not instituti	on, give street and number)			4b. City, To	wn, or Locat	ion of Death	reigus	4c. Cour	nty of Death	
			Citizen	s Narsing	2 Ho	me	they	re	Dels	race	1	tart	ord
	Funeral Director		5. Social Security Number 399–14–9308	6. Sex Z Ag	(In yrs. i 83	last birthday) Yrs.	If Under 1 Y Months D	Year If Un Days Hou	rs Min.	8. Date of Bi 7 Moeth 1	925 ^{ar)}	9. Birth	pplace (State or Foreign Intro Consin
g			Usual Residence of Decedent				1						
death with the Maryland	ehow id at	٦	MD Ha	rfo r d		y, Town or Lo berdee!							10d. Inside City Limits 1 Yes 2 No
the M	28a-f	ecto	10e. Street and Number	LIOIG	A	oer dee	10f. Zip Co	ode			10g. Citizen o	of What Co	
with	3a or	Funeral Director	404 Clover S	treet				21001			_	5.A.	, .
death	eme 2	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.	.S. 13.	Was Deceden If Yes, specify	t of Hispanio	Origin? (Spe	ecify Yes or N Rican, etc.)			ican Indian,
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Maryland 21215-0036	7 le mai reumai		19a. Informant's Name/Relation Mary Jo Romb				ng Address (S Clove)			al Route Numb	per, City or Tow	vn, State, Z	ip Code)
. 1 and	tem 2	1	20a. Method of Disposition	u (Bpouse)	20b. P		osition (Name matory or othe			Date	20c. Locatio		Town, State
mo	nent of ant: If I		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other	n 3 □Removal from State (Specify)			rris &		8/26/	2008	West C	heste	er, PA
Baltimore,	Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Iteme 23e or 28e-f show any Injury or other treumatic event, the Madical Examinar must be notified at once.		21. Signature Superal Service	France		22	Name and A Tarring Aberdee	Address of F g-Carg en, Ma	o Fune ryland	ral Ho	me ₃₃ 99 ^A	٠.	
			23a. Part1. Enter the disease, shock, or heart failure. Li	or complications that caused st only one cause on each li	d the death	h. Do not ent	ter the mode o	of dying, sucl	n as cardiac o	or respiratory	arrest,		Approximate Interval Between Onset and Death
	ysician Medical		Immediate Cause (Final disease or condition resulting in death)	a		BAC	TERE	WIH					Onset and Death
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) ' A	7.	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequ	uence of):	1000	200	B				
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X 68	ding ph	Med	IF FEMALE:	220 16 1100 0110000	-1								
Bo Geath	been signed by the ettending phy should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal	I death 3	Ectopic pregr Other (speci					Date of deliment	very Day Year
$f\mathcal{O}\mathcal{H}_{I}$ ords, P.O	ned by e detac	by Ph	Part II. Other significant condi	tions contributing to death b	out not rest	ulting in the u	nderlying caus	se given in P	art I.	23e. Did	tobacco use co	ontribute to	the cause of death?
ecord:	een sig									1	Yes 2□No	3 🗆 Pro	obably 4 Minknown
Rec	certificete hes b rector, page 2 sl	Completed								24a. Wa auto peri	s an 24 opsy ormed?	death?	topsy findings available completion of cause of
tal In T	tificet tor, pa	a	25. Was case referred to medic	al				26 F	Place of Death	1 Yes	2 No	1 ∐ Yes	No
1 KV I	direc	ToB	examiner? 1 ☐ Yes 2 Ø No	Hospital: 1 ☐ Inpatio	ent 2	ER/Outpatier	nt 3 DOA	Other			sidence 6 🗆 🤇	Other (Spec	city)
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RD I	death ctor: y the	ficat	3 ☐ Suicide 6 ☐ Coul	mined 288. Place of In	jury - At ho	ome, farm, str	M reet, factory, o	1 ☐ Yes		28f. Location	(Street and Nu	mber or Ru	ral Route Number,
A NO IN	rs effer	Certification:	4 Homicide deter	building, et	c.*(Specif)	y)				City or To	own, State)		
Form By Division of Vita	within 24 hours effer death. To the Funeral Director: Affer this certificete hes completely filled in by the funeral director, page 2	Medical	29a. Certifier 1 Cartify (Check only 2 Madical one)	ring Physician: To the best al Examinar: On the basis of and manner st	f examina	wledge, death tion and/or in	h occurred at t vestigation, in	the time, dat my opinion,	e and place, death occurr	and due to the red at the time	e cause(s) and , date and plac	manner as e, and due	stated. to the cause(s)
Toth	To 1	Σ	29b. Signature and title of certification	ier /	-1/	1 1	29c. L	icense numl	ber	6	29d. Date sig	ned (Month	n. Day, Year)
i)	H		30. Name and address of person	on who completed cause of o	death (Item	1 23a) (Type,	Print)	BU	LOW	NI	1210	5/0	/ <u>&</u>
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£	Registra	ar	HUG 2 9 2	1008 Bereia	K	bores	y .			- 2			

			For State Registrar	State of	Marylan	-	artment of H		and Me		giene	2008	27028	
9			1. Decedent's Name (First, Midd							. Date of Dea	ath	Year	3. Time of Death	
	Physicia /Medic		Nickolena T.				41 O'T T			ugust			12:35 A ^M	
	Examin	er	4a. Facility Name (If not institution Vantage House	n, give street and numi	ber)		4b. City, Town, or Columbi		Death			4c. County of Death Howard		
	Funeral	- 2	5. Social Security Number	6. Sex 7	'. Age (In yrs.		If Under 1 Year Months Days	If Under 2	Min.	Date of Birt (Month, Day NOV 2	h y, Year)	Co	hplace (State or Foreign untry)	
í	Director		195–16–8616 Usual Residence of Decedent	IUM ZUF	83	Yrs.				Nov. 2	26, I	924 Per	nnsylvania	
	ryland how at		10a. State 10b. County	/		ty, Town or Lo	cation						10d. Inside City Limits	
with the Mor	he Ma 8a-f s otified	ecto	MD Howard Columb				a 10f. Zip Code				10a Citiz	en of What Co	1 Yes 2 No	
	s 1 and 2 should be filed within 72 hours after death with the Marylan f Health and Mental Hygiene. I them 21 is marked other than "natural", or items 23a or 28a-f show tem 21 is marked other than "natural" or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	10e. Street and Number 5400 Vantage	Point Road	#316		21044			-	_	ed Stat		
	r death	nera	11. Marital Status	12. Was Deced	ces?	.S. 13.	Was Decedent of H If Yes, specify Cuba	lispanic Ori an, Mexicar	gin? (Speci	fy Yes or No- can, etc.)	. 1	4. Race - Ame Black, White		
0000	rs afte	by Fu	1 □ Never Married 2 ☑ Married 1 □ Yes 2 ☑ M 1 □ Yes, Give 3 □ Widowed 4 □ Divorced Year or Dates:				1 ☐ Yes 2 🕱 No	Specify:				Specify: Whi	ite	
721	72 hou natura lical E	ted	15. Decedent's Education 16a. De (Specify only highest grade completed) (G				edent's Usual Occupation					d of Business/		
	vithin 7	Completed	Elementary/Secondary (0-12)	1	e kind of work done during most of working DO NOT use retired) ice Manager				Retail					
	filed v Hygie other t ent, th	Be Co	12 17. Father's Name (<i>First, Middle</i>	, Last)		011	14149		er's Name (First, Middle,				
	wild be Menta arked a	To B	Andrew Rota				Philamina Lavir							
	1 and 2 should be filed within Health and Mental Hygiene. em 27 is marked other than other traumatic event, th. Me		19a. Informant's Name/Relation Paul W. Reuter				ng Address <i>(Street</i> Vantage							
3)	os 1 and 2. of Health a item 27 is other trau		20a. Method of Disposition	/ nusbana	20b. F		esition (Name of matory or other place		. NOau Da			cation - City or		
2	Page nent o int; If i		1 ☐ Burial 2 🙀 Cremation 4 ☐ Donation 5 ☐ Other (tate		rematory	1	8-19-	2008	Hano	ver, M		
Dallino	permit. Pages 'Department of H Important: If ite any injury or of once.		21. Signature of Funeral Service	Licensee MO10	44	22	2. Name and Addre	ss of Facilit	Harry	H. Wi	tzke	's Fami	ily FH, Inc.	
	00 = 00		23a. Part1. Enter the disease, of	or complications that ca	used the deat							t City	Approximate	
ı	Physician		shock, or heart failure. Lis Immediate Cause (Final disease or condition	st only one cause on ea	ch line. -ME/		4						Interval Between Onset and Death	
	/Medical Examiner		resulting in death)	a	or as a consec									
	LAdimiliei	ē.	Sequentially list conditions,	b. Due to (c	quence of):	>								
	cuted id ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events											
,00,	be executed ician and burial-transit		resulting in death) Last	nsequence of):										
-	ficate t physic s the b	edical		d										
×	w requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant	ancy al death 3[3 ⊟Ectopic pregnancy 5 □ Other (s <i>pecify</i>)				23d. Date of delivery Month Day Year					
5	requires that the death then signed by the atter hould be detached for u	/sicia	in the past 12 months? 1 ☐ Yes 2 🎞 No 9 ☐ Unknown											
Ţ.	that the	y Ph	Part II. Other significant condi	tions contributing to de	ath but not res	sulting in the u	inderlying cause given in Part I. 23e. Di				d tobacco use contribute to the cause of death?			
records,	equires en sign	ed by							☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown					
200	law re nas be	Completed			24a. Wa				topsy prior to completion of cause of		utopsy findings available completion of cause of			
_ ⊨			OF Man case referred to made	al				00 Pl	f D	1□ Yes	2X No	death? 1 ☐ Yes	s 2 No	
VICA	Physician; r this certific ral director,	o Be	25. Was case referred to medical examiner? 1 Yes 2 No									ecify)		
=	ng P fter t nera	on: T	On Date of Injury 29h Time of 29h Injury to 29h Describe how injury congred											
UIVISION OF Hospital or Attending Phy	I or Attending Phater death. Director: After the in by the funeral	icati	2 ☐ Accident inves 3 ☐ Suicide 6 ☐ Could	M 1∟ reet, factory, office	M 1 ☐ Yes 2 ☐ No et. factory, office 28f. Location			(Street and Number or Rural Route Number,						
	al or A s after al Dire ed in b	Certification:	4 ☐ Homicide determined building, etc. (Specify)					City or Tox			wn, State)			
	To the Hospital or Attendli within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Medical (the state of the s										
	To th within To th	Me	(Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month DS)								th, Day, Year)			
3	(m)		30. Name and address of person	n who completed cause	e of death (Iter	m 23a) (Type	Print) KE	NNE	TIM	GRE	=H,	100	1201.	
	Sta Registr		31. Date filed (Month, Day, Yea	5 2008 32.	gistrar's Sign	ature	berte							
DUA	4H 17 Bey 1/2		AUG I	5 E000 July		- 7		,						

			1 - For Stata Registrar	State of Ma	aryland /	•	artmen <i>tificat</i>			and Me		giene	008	27929
	0.,		1. Decedent's Name (First, Middle, La	st)	7					2	. Date of Dea	ath Day	Year	3. Time of Death
	Physicia /Medic		Lily K.	Smith						I A	August	22	2008	3:25 a. ^M
	Examin		4a. Facility Name (If not institution, give	e street and number)			4b. City,	Town, or	Location of	of Death		4c. Co	ounty of Deat	
М	Funeral		Moran Manor Nursing Home				Westernport						gany	
			Social Security Number 6. S		e (In yrs. last b	irthday)	If Under Months	1 Year Days	If Under Hours	24 Hrs. 8 Min.	. Date of Birtl (Month, Day	th ay, Year) 9. Birthplace (State or Foreign Country)		
	Director		233-34-6102	□M 2\\ F	83	Yrs.	WIOTHIS	Days	710010		ov. 5,	1924		ser, WV
	p ,		Usual Residence of Decedent 10a. State 10b. County		10c. City, Tox									10d. Inside City Limits
	anyla ahov	Ĕ	1	1	-									1 X Yes 2 □ No
	Ba-f	ectc	WV Minera	T		Keys						10 0"		
	vith ti	by Funeral Director	10e. Street and Number				10f. Zip					10g. Citize	n of What Co	ountry?
	s 23s	ral	322 Welch Street	1 10 111 10 1 115		10.1	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)					14	USA Race - Ame	riana Indian
	er de	une	11. Marital Status 1 □ Never Married 2 □ Married 1 □ Yes 2 ☒ No			13.	was Deced f Yes, spec	ent of Hi	n, Mexican	gin? (Speci i, Puerto Ri	can, etc.)	14	Black, Whit	
36	rs aft	УF	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	10	1 ☐ Yes 2 ☒ No Specify:						S	pecify:	Thite	
응	within 72 hours after death with the Maryland ene. Than "natural", or Itams 23a or 28a-f ahow Ita Madical Examinar must be malifled at	edt	3 ☐ Widowed 4 ⚠ Divorced Year or Dates: 15. Decedent's Education 16a. Decedent's Usual Occup					ecupation 16b.				of Business		
5	in 72	Completed	(Specify only highest grade completed) (Give kind of work done during most of working life. DD NDT use retired)											
7	with iene. thar		Elementary/Secondary (0-12)	College (1-4or 5	+)		todia						Colleg	e
ğ	Hyg othar ant,	BeC	17. Father's Name (First, Middle, Last,						18. Mothe	er's Name (i	First, Middle,	Maiden St	ımame)	
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural; or Items 23a or 28a-1 ahow any injury or othar traumatic avant, Ite Medical Examinational be multiled at once.	To B	Michael T. Stagg	s					Haz	zel K	Rals	ton		
ary	shound No		19a. Informant's Name/Relationship (Type, Print)	19	b. Mailir	ng Address	(Street a	and Numbe	or or Rural F	Route Numbe	r, City or 7	own, State,	Zip Code)
Ž	alth a	j	Franklin T. Smit	h/Son		Rt.	6, E	Box 6	5984 - 2	A Ke	eyser,	WV	26726	
ē,	s 1 a of Hei itam othe		20a. Method of Disposition		20b. Place	of Dispo	sition (Nar	ne of ther plac	e) \	Dat ugust	e 26	20c. Loca	tion - City or	Town, State
Ë	Page ent o nt: If ry or		1 M Burial 2 ☐ Cremation 3 ☐ 3 4 ☐ Donation 5 ☐ Other (Specif			-	•			200	8	Keys	ser, W	V
Ħ	mit.		^4 □ Donation 5 □ Other (Specify)											
Ö	permi Depa Impo any ir		Brun Hall 85 S. Main Street Keyser, WV 26726											
			23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate											
X	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit		Onset and Death											
			resulting in death) Due to (or as a consequence of):											
		je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence	e of):								
D.		iE	Cause (Disease or injury that initiated events	C										
ó		ical Examiner	resulting in death) Last Due to (or as a consequence of):											
8760,		ical		_ d							<u> </u>			
39	ng pl	Physician/Med	IF FEMALE:			Ť.				-				
Вох	th ce tendi		23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown							23d. Date of delivery Month Day Year				
Э. Н	e dea he at hed fo	sici									Month Buy 15th			
P. O.	that the death certific ed by the attending p detached for use as	by	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.								. contribute to	the square of death?		
Ś	w requires that been signed b should be deta		Process again. Demonstric. Hyperstonation									robabiy 4 🛣 Unknown		
orc	requi een s nould	ted	24a. Was an autopsy							105 2	The state of the s			
Records,	las b	ple								osy	prior to completion of cause of			
<u> </u>	ystolan: The is certificate hadirector, page	To Be Completed									perfo	rmed? 2 X No	death?	2 □ No
Ħ			25. Was case referred to medical examiner?							of Death (Check only o	ne)		
<u></u>	Physi this c al dire		1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)									ocify)		
Division of Vital	Attanding Physician: If death. actor: After this certifice by the funeral director, i	iuo!	27. Manner of Death 28a. Date of Injury Natural 5 Pending 28b. Date of Injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Unity Work?											
S.	tand leath tor: /	cat	2 Accident investigation M 1 Yes 2 No 3 Suicide 6 Could not be 288 Place of Injury At home farm street factory office.							10				
\leq	or Attano after death Diractor: in by the	Certification;	286. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						lf. Location (Street and Number or Rural Route Number, City or Town, State)					
	To the Mospital or Attanding Ph within 24 hours after death. To tha Funaral Diractor: After th completely filled in by the funeral	Medical Ce	Continue W Continue Designation To the board state of									n stated		
	Hos 24 ho Fun tely t		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									e to the cause(s)		
	To the Hospital within 24 hours a To the Funeral I completely filled									29d. Date	. Date signed (Month, Day, Year)			
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	110		On Norman and	nomploted as: == = = = = =	onth (Hom DC -							22/08		
	4		30. Name and address of person who Jesus Tan, M.		eath (Item 23a adway		ostbu	ırg.	MD	21532	2			
	Sta	te			ar's Signature			-63			_			
•	Registr		31. Date filed (Month, Day, Year) AUG 2 9 2008	Block		084								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Aug 20, 2008 0728 Shirey Patricia /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany <u>WMHS--Braddock Cam</u>pus Cumberland If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours 1 ☐ M 2 ☐ F ΜD Dec 15, 1936 Director <u> 215-34-4746</u> Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County if Health and Mental Hygiene. Item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1∐Yes 2∐No Allegany Cumberland MD Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21502 USA 905 Kentucky Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2X☐ No If Yes, Give Year or Dates: 1 Never Married Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Ş Q 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 homemaker <u>own home</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Georgette Scarlett John William Scarlett 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MD 21502 905 Kentucky Avenue Cumberland James Shirey husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 8/23/2008 Sunset Memorial Park MD Cumberland 4 ☐ Donation Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, PA 21. Signalure of Funeral Service Licen 108 Virginia Avenue: Cumberland, MD 21502 u d e death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ea h line. Appro.:imate Interval Between Onset and Death 23a. Part1. Enter the shock or hear Immedia - Cause (Final disease or condition resulting in death) ARDIOGENIC SHOCK **Physician** /Medical Examiner ECENT MYOCARDIAL INFARCTION S DAYS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying that initiated events resulting in death) Last Examine the Hospital or Attending Physician: The law requires that the death certificate be executed ARTHEROSCLEROSIS and Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, physiclan Physician/Medical IF FEMALE: 23c. If ves. outcome pf pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 ☐ Fetal death 3 ☐Ectopic pregnancy Month in the past 12 months? Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 3 Probably 2 No 1 ☐ Yes 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy perform 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death.

To the Funeral Director: / 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only

DHMH 17 Rev 1/2001

State Registrar 31. Date filed (Month, Day, Year) 2008 AUG 2 9

30. Name and address of person who complete

of certifier

one)

29b. Signature ar

DIAGNOSTIC CTR. CUMBERLAND 32. Registrar's Signature

led cause of ceath (Item 23a) (Type, Print)

and manner stated.

29c. License number

D0067438

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Dav Year Month **Physician** Josephine E. Skrabak 2008 August 22 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hagerstown
Hagerstown
Hunder 24 Hrs. Washington County Hospital Washington

9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex **Funeral** Min. 1 □ M 2 🛛 F Months Days Hours Director 297-22-1307 79 Ohio November4,1928 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location show 10a. State item 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Michael Experiment rust be restricted at 1 ☐ Yes 2X No Director Maryland Smithsburg Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 72 hours after death with 21783 U.S.A. 105 Jasons Ridge Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify ò Specify. White 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) . Pages 1 and 2 should be filed within imment of Health and Mental Hygiene. tant; If item 27 is marked other than " Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George Yakubisin <u>Anna Martonak</u> 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kevin Skrabak 105Jasons Ridge, Smithsburg, Maryland21783 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages Department of Important; If it any injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 MOther (Specify) Entombment St. Paul Cemetery 8-27-08 Weirton, West Virginia 22. Name and Address of Facility Marzullo Funeral Chapel, P.A. 21. Signature of Funeral Service Licensee michael 6009Harford Road, Baltimore, Maryland21214 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Neut Rend Fritum **Physician** 4-5-5 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner 4-500 Sapons Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine min Th attending physician and for use as the burial-tran Due to (or as a consequence of): certificate be Physician/Medical IF FEMALE: yes, outcome of pregnancy □ Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 5 Other (specify) □Yes 2□No Ö 9 Unknown 9 Unknown ₫. s been signed the should be detailed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, \$ Dichos granhlons 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Calilis 24a. Was an autopsy performed? 1 ☐Yes 2 ☐No **Division of Vital** 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 (No 1 ☐ Yes 1 Depatient 2 ER/Outpatient 3 DOA ဥ 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: Hospital or Attending Jopital c. 24 hours after dec. --eral Director: Atte 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 24 hours a Funeral I Medical 1 🖵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D (8019 AV (23, 2008 tonet mo

State Registrar 31. Date filed (Month, Day, Year)

AUG 2 9

32. Registrar's Signature

340

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

20

DATTA

2008

MILL ST HALERSTOWN, MOZITHO

08-06445 Stephanie Linn S	tau	Please Type or Print in Black In State of Maryland / Depa				ible.					
		- For State Cel	rtificate of D		Reg	. No. 200	19 2700				
Physicia	n/	Decedent's Name (First, Middle,Last)		To the second	2. Date of Death Month August 23,	Day Year	3. Time of Death 3				
Medical Examir	iei	STEPHANIE LYNN STAUBS 4a. Facility Name (if not institution, give street and number)	4b.	City, Town, or Location of Dea		4c. County of Death					
l.		8416 Reicherd Road	F	airplay		Washington					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. I		If Under 1 Year If Under 24H Months Days Hours M	in	(MM/DD/YYYY) 9. Birth Foreign	1				
Director		212-50-8488 1 M 2XF 47	Yrs.		NOV. 16	, 1960 Cou	intry) MARYLAND				
any	ł	Usual Residence of Decedent	, Town or Location				10d. Inside City Limits				
and show nce.	٦	MARYLAND WASHINGTON		FAIRPLAY			1 Yes 2 X No				
Maryll Maryll r 28a-f	Director	10e. Street and Number	1	Of. Zip Code	100	g. Citizen of What Coun					
5 722 72 hours after death with the Maryland 12 hours after death with the Maryland 14 hours after at once.		8416 REICHARD ROAD 11. Marital Status 12. Was Decedent Ever in U	S 13 Was F	21733 Decedent of Hispanic Origin? (Specify Yes or No-	U.S.A.					
eath w	Funeral	Never Married 2 X Married 1 Yes 2 X No		specify Cuban, Mexican, Puer		White, etc.					
after d	by Fi	3 Widowed 4 Divorced If Yes, Give Year or Dates:		es 2 X No specify:			THITE				
hours hours		15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		Usual Occupation (Give kind of of working life, DO NOT use r		16b. Kind of Business/li	ndustry				
336 thin 72 re than	Completed	12	, i	HOMEMAKER		OWN I	HOME				
5-0(iled wi Hygiel I other		17. Father's Name (First, Middle, Last)			me (First, Middle, M						
2121 Id be f Mental narked event,	To Be	JOSEPH LEE DEENER 19a. Informant's Name/Relationship (Type, Print)	19b. Mailing A	EDITH 1	LOUISE TRO		Zip Code)				
AD 2 show h and 1 27 is r umatic		DAVID L. STAUBS/SPOUSE		EICHARD ROAD,			21733				
re, re stand frealt free free free free free free free fre		20a. Method of Disposition 20b.		on (Name of cemetery,	Date	20c. Location - City or	Town, State				
imo Pages ment.o lant:]		4 Donetion 5 Other Specify: OLI					E, MARYLAND				
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner		2) Signature of Funeral Service Licensee		ne and Address of Facility $_{ m BA}$ $\sim 01d$ National							
Physician		23a. Part I. Enter the disease or complications that caused the death	n. Do not enter the	mode of dying, such as cardia	c or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and				
/Medical / xaminer		failure. List only one cause on each line. Immediate Cause (Final disease a Diphenhydramí	ne and p	ropoxyphene in	ntoxicati	on	Death				
(Xammer		or condition resulting in death) Due to (or as a consequence of):									
	ЭĒ	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of the conditions)									
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of the consequence of	of):								
executed an and all - transit	E										
be exe sician a	edical	X UNPENDED X AMENDED 23a,27,	28a-f, p oted per	ME WE 853 83/22/	08 TT TT	T					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicia completely filled in by the funeral director, page 2 should be deached for use as the buria	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnant in the past 12 months?		death 3 Ectopic pres	gnancy	23d. Date of delivery Month	/ Day Year				
Box 6 e death cer the attendi	sicia	1 Yes 2 ✓ No 9 Unknown g Unknown	eath 5 Othe	r (Specify)							
O. Bo nat the de d by the		Part II. Other significant conditions contributing to death but not	resulting in the und	derlying cause given in Part I.		bacco use contribute to					
s, P.O. ires that the signed by the detached	d by				_ 1 Yes	2 No 3 Prot					
tal Records, cian: The law requir certificate has been sector, page 2 should	Completed				24a. Was a autops	sy prior to o	itopsy findings available completion of cause of				
Reco	Com				perfor		es 2 No				
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2	ER/Outpatient	26.Place of Death (Che		Residence 6 ✔ Othe	r: Scene				
of Vital Records, ing Physician: The law require. After this certificate has been si uneral director, page 2 should	- To	1 ✓ Yes 2 No Imparent 2 27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of Inju			low injury occurred					
ion (tendin eath.	Certification:	Natural 5 Pending Fnd 8/23/08	Fnd 5:3	0 am ¹ Yes 2 X No	unk						
Division tal or Attendi rs after death. al Director: /	tifica	3 Suicide 6 X Could not be 28e. Place of Injury - At I	nome, farm, street, lat home	factory, office building, etc.	28f. Location (S	treet and Number or Rutate) 8416 Red	ural Route Number, City Lchard Rd				
Divisior Hospital or Attend 24 hours after death Funeral Director: ttely filled in by the		4 Homicide determined (Specify) 1 Guild 29a. Certifier 1 Certifying Physician: To the best of my knowled									
Division of North Hospital or Attending Physiph 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Medical	(Check only one) 2 Medical Examiner: On the basis of examination and manner stated.	and/or investigatio	n, in my opinion, death occurre	ed at the time, date	and place, and due to the	ne cause(s)				
E W E 22	Me	29b. Signature and title of certifier		29c. License number		29d. Date signed (Mo					
		Down int imis		O.C.M.E.		August 24, 2008					
Ø		 Name and address of person who completed cause of death (Iter Donna M. Vincenti, MD Assistant Medical Exa 		Penn Street, Baltimore,	MD 21201						
St	ate	31. Date filer (Morkh, Day Year) 000 32. Registrar's Signa									
Regist	rar	HUU 29 2000 PROBLES ST	Mark Contract of the Contract								

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1:20pm 16 2008 Margaret C. Stackowitz August /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Howard Ellicott City Nursing & Rehab Ellicott City If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 🕱 F Sept 26,1926 Maryland 81 Director 216 24 1910 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 28a-f show 1 ☐ Yes 2 XNo notified Director MD Columbia Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ral", or Items 23a or Examiner must be r United States 21044 10814 Green View Way Funeral 14. Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married 1 ☐ Yes 2 No Specify: þ White 3 Widowed 4 Divorced 'natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) than Elementary/Secondary (0-12) College (1-4or 5+) 12 Own Home Homemaker is marked other or other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be William Mannion Margaret McHale ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret McMillian/Daughter 10814 Green View Way Columbia, MD 21044 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Ardent Crematory 8-18-2008 Hanover, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. Signature of Funeral Service Licensee M01044 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CEREBRO VASCULAR **Physician** ACCIDENT disease or condition resulting in death) a. ACUTE days /Medical Due to (or es a consequence of): Examiner YSPHAGIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Monuts END STAGE DEMENTIA burlal-trar Due to (or as a consequence of): physician Physician/Medical the as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1☐ Yes 2 🛱 No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 I Inknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ cate has been si page 2 should b 1 ☐ Yes 2 No 3 Probably → Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? /es 2X No 1☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 📋 Inpatient 2 ER/Outpatient 3 DOA P funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 5 ☐ Pending investigation Injury 1 🔀 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

Box 68760. pe P.O. Records. Division or Vital

72 hours after

Baltimore, Maryland 21215-0036

the

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A death. filled in by

Medical

State Registrar

Shakunma 31. Date filed (Month, Day, Year)

4 Homicide

(Check only one)

29b. Signature and title of certifier

29a. Certifier



D0053150

29d. Date signed (Month, Day, Year)

senhora Rd Suite 110

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number

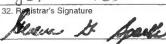
🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Aug 18, 2008 Colymbi

Speple 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Supte

AUG 1 8 2008



			For State Registrar	State o	of Marylan		artment of F		and Mei		iene _{eg. No.} 2 (008	27	934
LA	Physicia /Medic		1. Decedent's Name (First, Midd		H EVELYN	SHAFF	ER			Date of Deat Month August		00 ^{¥ear}	3. Time of 1:20	Death A M
	Examin	44	4a. Facility Name (If not institution Citizens Care				4b. City, Town, or Frederic		Location of Death			nty of Death erick		
	Funeral Director		5. Social Security Number 217–16–2541	6. Sex 1	7. Age (In yrs. 84	1	If Under 1 Year Months Days	24 Hrs. 8. Min. No	Date of Birth (Month, Day, V • 4 ;	ř ⁹ 23	9. Birthr	place (State o	or Foreign	
uld be filed within 72 hours after death with the Maryland	Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	10e. Street and Number 1900 Rosemont 11. Marital Status 1 □ Never Married 2□ Ma 3 ☑ Widowed 4□ Divorce	Avenue 12. Was Dec Armed Find It Yes It Yes G d	Fredent Ever in U. orces? 2 \textbf{N} No ive Dates:	16a. Deced (Give life. L		lispanic Originan, Mexican Specify: Pation during most	t of working	y Yes or No- can, etc.)	16b. Kind of Own Maiden Surn	of What County A • ace - Americ lack, White, cify: Wh Business/in	ntry? can Indian, etc.	ity Limits 2 No
ages 1 and 2 sho	nt of Health and h : If item 27 is ma : or other trauma		19a. Informant's Name/Relation Lorriane Ander 20a. Method of Disposition ↑□ Burial 2 □ Cremation	s/ Niece 3 □Removal from	State	1612 lace of Dispo emetery, crer	Rock Cree sition (Name of natory or other place	ek Dri	ive Ap	ot. 11,	Fred	erick,	MD 21	
егтіt. Ра	Departmer Important: any Injury once.		4 □ Donation 5 □ Other (21. Signature of Funeral Service		Mt.		t Cemeter Name and Addre BERT E. I		3/15/0 ½ & so				larylar P.A.	ıd
Pi	cian and maintenair stransit can and can and can and can are can be considered as a constant of the constant o	dical Examiner	23a. Part1. Enter the disease, concept of the disease, concept of the disease of the disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying cause (Disease or injury that initiated events resulting in death) Last	b		onia uence of): Lls uence of): Lha	01 NORTH er the mode of dylr	ng, such as	ET ST v	FRED espiratory arre	ERICK ,	, MD 2	Approxima Interval Ber Onset and	lween
The law requires that the death certificat		by Physician/Me	in the past 12 months? 1									Day	Year death?	
Physician: The law requi		Be Completed	25. Was case referred to medic examiner?						of Death (C	1 ☐ Ye 24a. Was al autops perforr 1 ☐ Yes 2 Check only on	n 24	b. Were auto	oppy findings oppletion of c	available
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To the Hospital	within 24 hours To the Funeral completely filled	29a. Certifier (Check only one) 29b. Signature and title of fertifier 29b. Signature and title of fertifier 29c. License number 29d. Date signed (Month, De Do Do Do Do Do Do Do Do Do Do Do Do Do												
1	Sta Registr	_	30 Name and address of person 31. Date filed (Month, Day, Year	Nagu	se of death (Item	W.	Print) +n 3	st, F	rede	rick,	Md.	2170)	0
1.15.41	17 Day 1/0/	201		-	1									

1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** AM Eileen Phyllis Shirk 4:00 AUgus 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner PERRY 1 A MACYLAND HEALTH CARE SYSTEM

5. Social Security Number 6. Sex 7. Age (In yrs. last birth Peint eci If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In vrs. last birthday 8. Date of Birth (Month, Day, July 17 **Funeral** Year) 1 □ M 2 🗓 F Days Hours Min. 173-32-0292 68 Pennsylvania Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2X No Maryland Anne Arundel Riva the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 23a P.O. Box 161, 309 Cove Road 21.403 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces?
1 XYes 2 ☐ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No Specify: ğ Specify: 3 ☐ Widowed 4 ☑ Divorced Year or Dates: 1958-61 White "natural" Completed event, the Mudical 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) V.A. Maryland Healthcare System 1 and 2 should be filed within 7 Health and Mental Hyglene. College (1-4or 5+) VO Years Elementary/Secondary (0-12) Medical Assistant Perry Point, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be marked Earl Oscar Kendig Maria Mancuso ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) S Deborah I. Tax (daughter) 4065 Foothill Road, Santa Barbara, CA permit. Pages 1 and Department of He 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Important: If it any Injury or c 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 08-22-08 Owings Mills, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Lee A. Patterson & Son Funeral Home, P.A. Perryville, Maryland 21903-0766 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Multisystem Organ
Due to (or as a consequence of): Faul disease or condition resulting in death) UNKNOWN /Medical Examiner Failur Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a consequence of The law requires that the death certificate be executed Carcinoma ndometrial attending physician and for use as the burial-trai Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3

Ectopic pregnancy in the past 12 months? Month Year Day Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 □ Yes 2 X No 1 ☐ Yes director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To funeral 28a. Date of Injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death.Funeral Director: After the 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 □Yes 2 □No 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a 29a. Certifier 🔯 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the I within 2. 29c. License number TA State. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MD OTAL9a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MAMoryland Health Care System, Perry Point, MD 21902 HOCK M.D. 10+1 VA DeDorAN 32. Reistrar's Signature 31. Date filed (Month, Day, Year) State AUG 1 8 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Certificate of Death

State of Maryland / Department of Health and Mental Hygiene 2008

3. Time of Death

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No./ 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Vear Shen 8 12 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Bathware
If Under 1 Year | If Under 24 Hrs. of Naryland Medical 8. Date of Birth (Month, Pay, Year) Feb. 19,1938 Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. Hours Months 1**X** M 2□ F 70 573-66-1289 China Usual Residence of Decedent 10a. State 10c. City, Town or Location 10h. County 10d. Inside City Limits MD North Potomac Montgomery 1 □Yes 2 No 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 20878 11109 Freas Drive United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 If Yes, Give Year or Dates: 2 **X** No 1 Never Married 2 X Married 1 ☐ Yes 2 🗓 No Specify: Asian 3 □ Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Department of College (1-4or 5+) Elementary/Secondary (0-12) Chemical Engineer Energy 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Chung-Lin Shen Jenny Tu 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11109 Freas Drive North Potomac, MD 20878 Han Yin Shen (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Aug. 16, Silver Spring, MD Gate of Heaven Cem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DeVol Funeral Home 10 East Deer Park Dr. Gaithersburg, MD 20877 23a. Part1. Enter the disease, or complications accused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final nocardial resulting in death) Due o (or as a consequence of): Alvedar 3 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of): 23c. If yes, outcome pf pregnancy 1□Live birth 2□ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an 1□ Yes 2 NO 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? Injury

Physician /Medical Examiner

certificate be executed

Division or Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

28a-f show notified at

"natural", or items 23a or

other traumatic event, the Medical

Is marked other

within 72 hours after death

filed within Hygiene.

2 should be fill and Mental H

is 1 and 2 s of Health an

permit. Pages 1 a
Department of He
Important: If item
any injury or othe

Baltimore, Maryland 21215-0036

Director

Funeral

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Completed

Be

and attending physician the. as nse for the page 2 s certificate has director this

Examiner Physician/Medical þ Completed Be ဥ funeral c After t Certification:

within 24 hours a Hospital To the (10

filled in by the

Medical

State

Registrar

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death 1 Natural 2 Accident 3 Suicide

4 Homicide

(Check only

29a. Certifier

5 Pending investigation 6 Could not be determined

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State) 🛮 💢 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year) 487813721

Bathmore, MD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

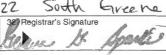
22

and manner stated.

Kristin Thanavava 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

15 2008 AUG



South

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene 008 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death AUGUST **Physician** ISAAC R. TAYLOR 2008 12:45 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner HAVRE DE GRACE HARFORD HARFORD MEMORIAL HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 15€M 2□ F Yrs. 75 Director 220-34-6812 SEPT 28. 1932 PENNSYLVANIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23a or 28e-f ahov other traumatic event, the Medical Exampler must be notified at 1 No 2 No Director MARYLAND HARFORD HAVRE DE GRACE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4147 GRAVEL HILL ROAD 21078 USA 12. Was Decedent Ever in U.S. Amed Forces? 1 ☐ Xes 2 ☐ No tYes, Give Year or Dates: 1953--55 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: BLACK þ Specify 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) DIETETIC SUPERVISOR VA HOSPTIAL 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 should be f and Mental I ISAAC ROLAND TAYLOR, SR. ELIZABETH WATKINS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARY F. TAYLOR / SPOUSE 4147 GRAVEL HILL ROAD, HAVRE DE GRACE, MD 21078 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Surial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) ST. JAMES CEMETERY 08/23/08 HAVRE DE GRACE, MD 21. Signature of Funeral Service Licensee 22. Name and Address o LISA SCOTT FUNERAL HOME, P.A 552 LEWIS STREET, HAVRE DE GRACE, MD 21078 Respiratory Falluce

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Respir 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury the initiated as or injury Examine physicien and the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 Yo
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contribution 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? 1 🗌 Yes 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Inpatient 1 ☐ Yes 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Natural 2 Accident Division 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Direct 4 | Homicide ō within 24 hours To the Funerel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier who completed cause of death (Item 23a) (Type, Print) HERFORD MEMORIAL HOSPITAL ASS TIVA AVENUE, HAVRE UKION State Registrar

08-06157 Gerald Roy Tuli Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene

2008 27938

a rioy ran		For State	Certifica	ate of	Death		Reg. N	lo	3. Time of Death
Physiciar ical Examin	1 1.	Decedent's Name (First, Middle,Last) Gerald Roy	Tul1				Date of Death Month Da August 12, 2	308	1032 hrs
		Facility Name (if not institution, give str Civista Medical Center	eet and number)	4	o. City, Town, or Lo La Plata			4c. County of E Charles	
Funeral Director		Social Security Number 6. Sex	7. Age (In yrs. last birt	hday) Yrs.	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Birth (F	1	3. Birthplace (State or Foreign Country) Maryland
, , k	Ü	sual Residence of Decedent Oa. State 10b. County	10c. City, Town	or Location	on				10d. Inside City Limits
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Marylar 28a-f s d at on	Director	0e. Street and Number			10f. Zip Code 20625		Tog.	USA	. ood.ii.y
b, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland and 2 should be filed within 72 hours after death with the Maryland ten 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once traumatic event, the Medical Examiner must be notified at once			Was Decedent Ever in U.S. Armed Forces?	13. Wa	s Decedent of Hisp es, specify Cuban,	oanic Origin? (Spe Mexican, Puerto F	ecify Yes or No- Rican, etc.)		American Indian, Black, etc.
or death	Funeral	Never Married 2 Married Widowed 4 Divorced	Yes 2 X No	1	Yes 2X No	specify:		Specify:	White
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21213-UU30 vuld be filed within 7 Montal Hygiene. marked other than ic event, the Medica	5	17. Father's Name (First, Middle, Last)				18.Mother's Name	(First, Middle, Ma Salloway	iden Surname)	
Id be fill Montal B	o Be	James Roy Tull, J	e, Print)	9b. Mailin	g Address (Stree			er, City or Town	, State, Zip Code) 0715
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2 - 2 - 3		20a. Method of Disposition 1 Burial 2 X Cremation 3	arem.	atomy or o	her nlace	- 1	3/15/08	Charlot	te Hall,MD
Baltimol permit. Pages Department ol Important: I		4 Donation 5 Other Specify: 21. Signature of Funeral Service License	M01458	22.	NAME AND ROTTES	CHOUS FU	NERAL HO	OME, P.A.	20646
		Manuel Lundam 23a. Part I. Enter the disease, or compli	cations in a caused the death. Do	not enter	211 St. N the mode of dying,	lary's Av , such as cardiac o	re. La P r respiratory arre	st, shock, or hea	Approximate Interval Between Onset and
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Hilling		b	ue to (or as a consequence of):						
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ed nsit	Examine	(Disease or injury that initiated events resulting in death) Last	ue to (or as a consequence of):						
760, icate be executed physician and the burial - transit	Medical	UNPENDED	AMENDED					Tool Date of	fdelivery
P.O. Box 68760, s that the death certificate be gned by the attending physic e detached for use as the bur	ician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregnant Live birth 4 Pregnant at time of death	2	Fetal death 3 Other (Specify)	Ectopic pregn	ancy	23d. Date of Month	Day Year
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Vital Rec ysician: The l his certificate l director, page	To Be	examiner?	lospital: 1 Inpatient 2 🗸 E			Other Nurs	sing Home 5	Residence 6 how injury occu	Other:
ding Ph	on: T	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b. Time		Yes 2 No			
Division of Vital Records, the low require is after death. The three rectificate as there are a forecare. After this certificate has been size in by the fineral director, page 2 should be led in by the fineral director, page 2 should be	Certification:	2 Accident Investigat 3 Suicide 6 Could not	be 28e. Place of Injury - At hom	ne, farm, s	treet, factory, office	e building, etc.	28f. Location or Town,	(Street and Num State)	nber or Rural Route Number, Ci
Division of Vital Records, P.O. E no the Hospital or Attending Physician: The law requires that the within 24 hours after death. The this certificate has been signed by the formeral Director: After this certificate has been signed by the controllery till the thinest director, page 2 should be deather.	al Cert		ian: To the best of my knowledge r: On the basis of examination and	e, death or	courred at the time.	, date and place, a	and due to the cau	se(s) and mann and place, and	ner as stated. If due to the cause(s)
To the within To the	Medical	one) 2 Medical Examine 29b. Signature and title of certifier	r: On the basis of examination and and manner stated.	JOI MIVES	29c. Lice	ense number		29d. Date si	gned (Month, Day, real)
	2	hull as	~ ~0		0.	C.M.E.		August 1	3, 2008
		30. Name and address of person who	completed cause of death (Item 2 Assistant Medical Exami	23a) iner	I11 Penn Stre	et, Baltimore,	MD 21201		
DB 20		Russell Alexander MD. e 31. Date filed (Month, Day, Year) AUG 1 5	32. Relistrar's Signatur						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death *lasquez* Facility Name (If not institution, give street and number, 4b. City. Town, or Location of Death County of Death 5. Social Security Number Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Year) 1 □ M 2 ■ F Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 2 No 3 ₩idowed 4 Divorced DhITE 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) STODIAN MANAGEMENT CO. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Physician /Medical Examiner

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinal Insist be notified.

Baltimore, Maryland 21215-0036

29a. Certifier

29b. Signature and title of certifier

(NEMAND 31. Date filed (Month, Day, Year)

AUG 2 9 2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print

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32. Registrar's Signature

s after death filled in by To the Hospital o within 24 hours af To the Funeral Di

or Attending Physician: The law requires that the death certificate be execute Division of Vital Records, P.O. Box 68760,

	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specia		20b. Place of Dispos cemetery, cremi	ition (Na atory or d	ime of other place)	!		Location - City or			
	21. Signature of Funeral Service Licer	nsee C	ACCENT CA	Name a	nd Address of F	Pacility DAU	GHERTY FAR	T. 2112	AN HOME		
	23s. Part 1. Enter the disease or ome shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause an wich line	e death. Do not ente	r the mo	de of dying, sud	ch as cardiac o	r respiratory arrest,		Approximate Interval Between Onset and Death		
iner	resulting in death) Sequentially list conditions, if any leading to him additionable cause. Einter Underlying	b. Due to (or as a	10 YEARS								
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Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1										
ed by Pr	Part II. Other significant conditions of	contributing to death but	not resulting in the und	lerlying (cause given in F	Part I.	23e. Did tobacc		o the cause of death? Probably 4 ☐ Unknown		
Completed by							24a. Was an autopsy performed? 1 □ Yes 2 ▼	death?	utopsy findings available completion of cause of		
Be	25. Was case referred to medical examiner?				26.	Place of Death	(Check only one)				
2	1 Yes 2 □ No	Hospital: 1 🔲 Inpatien	t 2 ER/Outpatient	3 🗆 D	OA Other: 4	☐ Nursing Hon	ne 5 Residence	6 ☐Other (Spe	ecify)		
ation:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year) 28b. Time of Injury at Work? M 1 □ Yes 2 □ No 28d. Describe how injury occurred						jury occurred			
Sertification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury building, etc.	y - At home, farm, stree (Specify)	et, factor	28f. Location (Street and Number or Rural Route Number, City or Town, State)						

State

Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

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CANDMARK DRIVE

29d. Date signed (Month, Day, Year)

08-26-2008

GLEN BULNIE

21061

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day Year **Physician** WINTER 08 80 0915 HELEN /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death WMHS BRADDOCK CAMPUS ALLEGANY CUMBERLAND If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Sep 7, Birthplace (State or Foreign Country)
 MD 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Hours Months Days 1 □ M 2 □ F 219-10-2998 **Director** 82 Usual Residence of Decedent death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show the Medical Examiner must be notified at PA Bedford Artemas 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 2 220 Covered Bridge Rd 17211 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 Ď No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Pages 1 and 2 should be filed within 72 hours after rent of Health and Mental Hygiene. and the than "natural", or file ant! I flem 27 is marked other than "natural", or file ury or other traumatic event, IF. Medical Examination 1 ☐ Never Married 2 Married 1 □ Yes 2 □ **X**o Specify: \$ 3 Widowed 4 Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) C & P Telephone Operator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Koutnik Anna Koutnik မှ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joseph Winter 220 Covered Bridge Rd Artemas PA 17211 husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date Department of Important: If It any Injury or o once. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Scarpelli Funeral Home, P.A. 8/24/2008 Cresaptown MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funer Service Licen 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one bause on each line. Approximate Interval Between Onset and Death Physician ena years resulting in death) /Medical Due to (or as a consequence of) Examiner iabetes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transi Due to (or as a consequence of): attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Year Day 5 ☐ Other (specify) 1 ☐Yes 2 🗷 No After this certificate has been signed by the funeral director, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 No 1 □Yes 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 ☐ Accident investigation

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Hospital or Attending Physiclan: The law requires that the death certificate be executed within 24 hours after death

To the Funeral Director:
completely filled in by the

9

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

29b. Signature and title of certifier · Ohver

6 Could not be determined

29c. License number **D00 23 77 4**

1/C CertifyIng PhysIcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

39d. Date signed (Month, Day, Year) August 33, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

For Name and address of person who combined cause of death (Item 23a) (Type, Print)

Paul T. Livengood MD 912 Seten Drive Cumberland Maryland 21502

State Registrar 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Andrew Joseph Walsh II 2:45 A M August 25, 2008 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 13436 Cherry Tree Circle Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 ☑ M 2 ☐ F Yrs. 068-32-8548 68 April 24, 1940 New York Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ▼ No MD Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13436 Cherry Tree Circle 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1♥1Yes 2□No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No 3 Widowed 4 Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Account Executive Insurance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Andrew Joseph Walsh Regina Hogan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte C. Walsh/Wife 13436 Cherry Tree Circle, Hagerstown, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 8/29/2008 Hagerstown, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel 1601 Pennsylvania Ave., Hagerstown, MD 23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence o): disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy Month Day cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☑ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mentai Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be provided.

altimore, Maryland 21215-0036

/Medical

Director

Funeral

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After this certificate

24 hours after death Property Process

within 24

Hospital or Attending Physician: The law requires that the death certificate be execu

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed R

1 Yes 2 No 9 Unknown	4□Pregnant at time of death 9□Unknown	5 ☐ Other (
rt II. Other significant conditions	s contributing to death but not resulting in	the underlying

Complei				24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No				
Be	25. Was case referred to medical examiner?		26. Place of De	ath (Check only one)				
P	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3	Home 5 ☐ Aesidence 6 ☐ Other (Specify)					
Certification:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigatio 3 ☐ Suicide 6 ☐ Could not be	he -	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred				
_	4 Homicide determined	28e. Place of Injury - At home, farm, street, fa building, etc. (Specify)	28f. Location (Street and Number or Rural Route Number, City or Town, State)					
Medical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	Physician: To the best of my knowledge, death occuminer: On the basis of examination and/or investigand manner stated.	re, and due to the cause(s) and manner as stated. Burred at the time, date and place, and due to the cause(s)					
2	29h Signature and title of certifier		29c License number	20d Detection of 44 to 14 D 14 to				

(Check onl one)	y 2 Medical i
29b. Signature	and title of certifier

Milamiel

29d. Date signed (Month, Day, Year) 8.25.08

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

11110 Medical 31. Date filed (Month, 2

941 State

Registrar DHMH 17 Rev 1/2001

		ı	For State Registrar	State of Mai	ryland / Depa <i>Ce</i>	artment of F rtificate of I			iene 2 0 0 (3 27942
	D1		1. Decedent's Name (First, Middle, Last,					2. Date of Deat	h Day Year	3. Time of Death
- 1	Physici /Medio		Donald Richard War	renfeltz,	Jr.			August	17 200	6 1217 M
	Examir		4a. Facility Name (If not institution, give			1	r Location of Death	Ū	4c. County of Dea	
			11208 Robinwood Di		(la var la et bioth de vi	Hagersto	WN If Under 24 Hrs.	0 Date of Birth	Washingto	
	Funeral Director		212-36-0779	7. Age M 2□ F 6	(In yrs. last birthday) 8 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day Sept • 27	thplace (State or Foreign ountry) yland	
	and		Usual Residence of Decedent 10a. State 10b. County	1.	10c. City, Town or Lo	ocation				10d. Inside City Limits
	with the Maryland a or 28a-f show by notified at	ট্	Maryland Washington	County :	Hagerstow	n				1 ☐ Yes 2 🔏 No
	r 28a	irec	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What Co	ountry?
	ath witi	a D	11208 Robinwood Dr			21742			U.S.A.	
Maryland 21215-0036	after dea or items	by Funeral Director	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1	1	Was Decedent of H If Yes, specify Cuba 1 □Yes 2 🛣 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Race - Am Black, Whit Specify: WI	
2-0	N 62 0	Completed	15. Decedent's Edu (Specify only highest grade	cation	16a. Dece	dent's Usual Occup	eation during most of work d)	ing	16b. Kind of Business	/Industry
21	ithin 7	n ple	Elementary/Secondary (0-12)	College (1-4or 5+)	J i		d)		.	1.0
21	ed wi lygier ner th nt, in			5+	Resea	archer				Research Com.
and Pug	2 should be filed w h and Mental Hygie is marked other t raumatic event, In	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name		nrrenfeltz	
ž	d Mer marke	ပ္	Donald R. Warrenfel	<u> </u>	405-84-00	A -l -l (C44				7:- Codel
Ma	d2sl Ithan I7 is r traur		19a. Informant's Name/Relationship (Ty John R. Warrenfelt:	•		-			; City or Town, State, $1, $	
	it. Pages 1 an rtment of Hea rtant: If Item 2 njury or other		20a. Method of Disposition		20h Place of Disno	esition (Name of	<u> </u>		20c. Location - City or	
Baltimore,			1 X Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		St. Paul Church Cei	netery	10 20		lagerstown,	· -
Bal	Depar Impo any Ir		21. Signature of Funeral Service License			Fiery Fundagerstown,				
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final	ati ns that caused the ause on each line	he death. Do not en	0		or respiratory arre	est,	Approximate Interval Between Onset and Death
-	Physician /Medical		disease or condition resulting in death)	Corona	Het en	so ill	as			
T	Examiner			Due to (or 15)	consequence of):					
	p ±	Jer	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence of):					
	cuted nd ransit	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last							
ó	e exe ian ar ırial-tı	Ë	resulting in death) Last	Due to (or as a	consequence of):					
68760,	ifficate be executed g physician and as the burial-transit	edical		l						
	± 50 SE	Mec	IF FEMALE:							
.O. Box	The law requires that the death cernate has been signed by the attendingage 2 should be detached for use	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	3c. If yes, outcome of 1 ☐ Live birth 2 4 ☐ Pregnant at ti 9 ☐ Unknown	Fetal death 3	☐ Ectopic pregnanc ☐ Other (s <i>pecify</i>) _	у		23d. Date of de Month	Day Year
ري ص	s that gned t	by PI	Part II. Other significant conditions cor	tributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did tob	pacco use contribute t	o the cause of death?
ıd	w require s been sig should b	edt						1 □ Ye	s 2 No 3 P	robably 4 ☐ Unknown
Records,	law re as be 2 sho	Completed						24a. Was a	n 24b. Were a	utopsy findings available completion of cause of
Ä	siclan: The law certificate has t irector, page 2 s	m o						perforr	ned? death?	s 2 No
of Vital	Physiclan: r this certific ral director, p	Be (25. Was case referred to medical examiner?				26. Place of Deat		e)	
£	hysik this c	P.	1√Yes 2□No		t 2 ER/Outpatie		4 🖂 Nursing Ho		ence 6 ☐ Other (Spe	ecify)
n C	iding Physiclan: th. After this certifical funeral director,	ion:	27. Manner of Death 11 ■ Natural 5 ■ Pending	28a. Date of Injury (Month, Day,	Year) 28b. Time o	Worl		28d. Describe ho	w injury occurred	
Sic	ttend death stor:	icat	2 Accident investigation 3 Suicide 6 Could not be	28a Bloss of Injury	y - At home, farm, str		Yes 2□No	20f Location (Ct		turned Davida Murrahan
Division	ital or Attender rs after death al Director; led in by the	Certification:	4 Homicide determined	building, etc.		City or Town	reet and Number or R n, State)	urai Houte Number,		
	To the Hospital or Attending within 24 hours after death. To the Funeral Director; After completely filled in by the funer	Medical			examination and/or in				ause(s) and manner a ate and place, and du	
	To the To the Complex complex	ž	29b. Signature and title certifier	m	+	29c. Licens	e number	2	9d. Date signed (Mon	th, Day, Year)
	il me		30. Name and address of person who co	mpleted cause of dea		Print)	7 11	1	mo i	2,7/6
S	H-5		Stophe Cote	251	F. Hatie	ton 2	ot, Ha	Kister -	ר מיוו	N 140
	Sta * Registr		31. Date filed (Month, Day, Year) AUG 1 9 20	32. Pogistrar	s Signature	mes .		.		
				E-						

	For State	State of Maryl		artment of H rtificate of L			ene g. No.2008	27943		
- 6	Registrar 1. Decedent's Name (First, Middle, Las	<u> </u>		tillouto of E		2. Date of Death		3. Time of Death		
Physician /Medical	ESTHER	WEIN	ER			AUGUST 8	Day Year , 2008	8:50 P M		
Examiner	4a. Facility Name (If not institution, give			127.74	Location of Death		4c. County of Deat	h		
	COLLINGSWOOD NURS 5. Social Security Number 6. Se		rs. last birthday)	ROCI	KVILLE If Under 24 Hrs.	8 Date of Birth	GOMERY hplace (State or Foreign			
Funeral Director			92 Yrs.	Months Days	Hours Min.	8. Date of Birth (Month, Day, 06/10/19	Year) Co	YORK		
pu >	Usual Residence of Decedent 10a. State 10b. County	100	City, Town or Lo	ocation				10d. Inside City Limits		
Aaryla F shov ed at or	,		-					1 ▼ Yes 2 No		
the Notific notific	MARYLAND MONTGOM 10e. Street and Number	EKI	ROCKVII	그나는 10f. Zip Code		10	10g. Citizen of What Country?			
23a ol	299 HURLEY AVENUE	#179			20850		USA			
ufter death with the Mar r Items 23a or 28a-f sl niner must be notified Funeral Director	11. Marital Status	12. Was Decedent Ever i Armed Forces?		Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No- Dican, etc.)	14. Race - Ame Black, White			
ar, or i	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☑ Divorced	1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		1 ☐ Yes 2 ☐ No	Specify:	Specify:	WHITE			
2 houranatura	15. Decedent's Ed	ucation	16a. Dece	dent's Usual Occupa	ation	king 1	6b. Kind of Business/	Industry		
ed within 72 ho ygiene. Per than "natur ht, the Medical E Completed	(Specify only highest grad	_								
Hygier Hygier ther th nt, the	12 17. Father's Name (First, Middle, Last)		"UNKI	NOWN''	18 Mother's Nam	ne (First, Middle, M	"UNKNOWN"			
Mental H arked ott arked ott artic even	ABRAHAM HYMAN				YELLA "U					
shou s mar sumat	19a. Informant's Name/Relationship (7	iype. Print)	19b. Mailii	ng Address (Street a	and Number or Ru	ral Route Number,	City or Town, State, 2	Zip Code)		
and 2 ealth in 27 I	CHERYL ELDER/SOCI							LE, MD 20850		
it of H	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	-	matory or other plac	e) :		20c. Location - City or			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licen	<u> </u>		HEL EMMES 2. Name and Addres		5/2008 C	APITOL HEI	GHTS, MD		
Department of the second of th	* (AAAAAAA)		DA	ANZANSKY-(GOLDBERG	MEMORIAL	CHAPELS, LLE, MARYL	INC.		
	23a. Part. Enter the disease, or comp shock, or heart failure. List only	lications that caused the cone cause on each line.						Approximate Interval Between		
Physician	Immediate Cause (Final disease or condition						NARY D	Onset and Death		
/Medical Examiner	resulting in death)	Due to (or as a con					,			
<u> </u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a con	sequence of):							
executed an and rial-transit	that initiated events	c								
icate be executed physician and sthe burial-transited ical Examir	resulting in death) Last	Due to (or as a con	sequence of):							
physicia physicia the bur	Ö d									
w requires that the death certification is been signed by the attending is should be detached for use as leted by Physician/Me	iF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome pf pre					23d. Date of del	ivery		
e death cert he attending led for use is sician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No	1 ☐ Live birth 2 ☐ I 4 ☐ Pregnant at time 9 ☐ Unknown		□Ectopic pregnancy □ Other (specify)	-		Month	Day Year		
hat the d by the detache	9 Unknown Part II. Other significant conditions or		reculting in the u	nderlying equal sive	en in Dort i	220 Did tob	acco use contribute to	the cause of death?		
signe d be d		ABETES	resulting in the d	ndenying cause give	siriii Faiti.	1 ☐ Ye	6	robably 4 Unknown		
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sician: The law certificate has to irector, page 2 s						autopsy	/ prior to	completion of cause of		
ertifica ector, p	25. Was case referred to medical examiner?				26. Place of Dea	th (Check only one		24110		
hysic this ce al direc	1 Yes 2 No		2 ER/Outpatier		Nursing H		nce 6 □Other (Spe	cify)		
After funers	27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time o	Worl	yat ⟨? Yes 2 □ No	28d. Describe ho	w injury occurred			
Ital or Attending F rs after death. ral Director: After led in by the funer: Certification:	3 Suicide 6 Could not be	28e. Place of injury - A			ics Z Ino		eet and Number or R	ural Route Number,		
s after s all Direction	4 Homicide determined	building, etc. (Sp	ecity)			City or Town	, State)			
	(Check only 2 Medical Exam	ysician: To the best of my iner: On the basis of exar	knowledge, deat nination and/or in	h occurred at the tin	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	ause(s) and manner as	s stated. e to the cause(s)		
o the Hosp ithin 24 hou o the Fune ompletely fi	one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)									
F 3 F 8		Dera, M	- >		57121		8 (13 10 g			
1	30. Name and address of person who	•		Print)						
		0110 Molecul		e, #206 1	Rockville	e, MD 208	50			
State Registrar	31. Date filed (Month, Day, Year) AUG 1 5 200	32. Registrar's S	K Ass	de						

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 08-03132 ' State of Maryland / Department of Health and Mental Hygiene Geraldine Wegener 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day April 22, 2008 2048 hrs Me 1 Examiner Geraldine Warren Wegener c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Anne Arundel Glen Burnie Baltimore Washington Medical Center If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Months Hours Jan. 8, Director 115-24-5925 1934 Country) New York 74 1 M 2 X F Usual Residence of Deceden 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 X Yes 2 No VAYork Yorktown es I and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or 28a-f sho notified at once Director 10g. Citizen of What Country 10f. Zip Code 10e. Street and Number 123 Mobjack Loop 23693 USA 14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X Married Yes 2 X No White Yes 2X No specify: Specify: If Yes, Give Yeer Widowed Divorced ð 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) other than "natur Completed during most of working life. DO NOT use retirad) Elementary/Secondary (0-12) College (1-4 or 5+) Registered Nurse Newport News Public Sch. Baltimore, MD 21215-0036 2 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be William Edward Annabelle Conroy 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Fred C. Wegener/Husband 123 Mobjack Loop Yorktown, VA 23693 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) Peninsula Funeral Home Crematorium 1, May Pages 1 1 Burial 2 X Cremation 3 Removal from State 2008 Newport News, Va. 4 Donation 5 Other Specify: 22. Name and Address of Facility DeVol Funeral Home 21. Signat uneral cice E 2222 Wisconsin Ave., N.W. Wash., D.C 20007 KARL 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval hysician een Onset and failure. List only one cause on each line fledical Death Complications of procedure for lumbar decompression Immediate Cause (Final disease .xaminer or condition resulting in death) Due to (or as a consequence of): and fusion Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director. Physician/Medical AMENDED 23a, PII, 27, perME, g883 9/4/08 TT X UNPENDED 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE: 23b. Was decedent pregnant in the Day Year Live birth Fetal death 3 Ectopic pregnancy 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 V No 3 Probably 4 Unknown þ Diabetes mellitus II, Hypertension, Hyperlipidemia Completed 24a, Was an 24b. Were autopsy findings available Hypothyroidism prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical å Other₄ examiner? Hospital: 1 Residence 6 Other Nursing Home 5 DOA Inpatient 2 V ER/Outpatient 3 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Yeer) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural Yes 2 No 5 Pending Investigation Accident 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifiar 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 23, 2008 O.C.M.E. 30. Nama and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Donna M. Vincenti, MD Assistant Medical Examiner Pegistrar's Signature 31. Date filed (Month, Day, Year) 2008 Registra

OCME

1. Decedent's Name (First, Middle, Last)

EDGAR FRANKLIN ZEPP III

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

2008

14

2. Date of Death

AUGUST

10:03 PM

Physician	
/Medical	
Examiner	

Director

Funeral

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Completed

Be

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Funeral Director

r 28a-f show notified at a or ns 23a "natural", or Items dical Examiner m I and 2 should be filed within 72 hours after the ith and Mental Hygier 27 is marked other the traumatic event, the of Health Important: If it any injury or c once.

altimore, Maryland 21215-0036

Physician /Medical Examiner

SEONARY ARTERY ZND STAGE Due to (or as a consequence of EREBROUASMU Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of Examiner death certificate be executed Uncontrolle burial-trar Due to (or as a consequence of): Box 68760, MURBI BE Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 4□Pregnant at time of death 5 ☐ Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division or Vital Records, sign ģ IT YPERTENSTON 1 Tyes Completed 24a. Was an HTPERCHOL Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient ို 2 No 1 ☐ Yes 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Certification: 1 Matural 5 Pending Jepital co.
4 hours after dea.
7 rai Director: A* 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after or
To the Funeral Direc 4 Homicide 29a. Certifier l 👺 CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ERIC CĬGANEK, 629 RAILROAD AVENUE, CENTREVILLE, MARYLAND 21617 M.D. 31. Date filed (Mor 1 8 2008 State Registrar DHMH 17 Rev 1/2001

4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) TALBOT 1020 N.WASHINGTON STREET EASTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JANUARY 23, 1946 9. Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) Days Hours Min. Months 1**X** M 2□ F MARYLAND 62 218-44-2955 Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 1 XYes 2 No MARYLAND TALBOT EASTON 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number UNITED STATES 1020 NORTH WASHINGTON STREET APT 1204 21601 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married WHITE 1 ☐ Yes 2 No Specify Specify: 3 ☐ Widowed 4 X Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) TRUCKING TRUCK DRIVER 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) JUNE A GETTMAN EDGAR F ZEPP, JR 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARK ZEPP/BROTHER 728 CLOVERFIELDS DRIVE, STEVENSVILLE, MARYLAND 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition AUGUST 15 1 ☐ Burial 2 XCremation 3 ☐ Removal from State CHESAPEAKE CREMATION 2008 STEVENSVILLE, MARYLAND 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME, P.A. 106 SHAMROCK ROAD, CHESTER, MARYLAND 21619 e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line. 23a. Part1. Enter the disease shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)

23d. Date of delivery Month Day

> 23e. Did tobacco use contribute to the cause of death? 2# No 3 Probably 4 Unknown

24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy performed?

Other: 4 ☐ Nursing Home 5 ■ Residence 6 ☐ Other (Specify) 28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Joseph **Physician** /Medical 4a. Facility Name (If not institution, give street and number, County of Death
Baltimore or Location of Death Examiner Seasons aspice Kandallstown If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Yrs. 9. Birthplace (State or Foreign Country) **Funeral** 228-50-379 1 M 2 □ F Months Year) Director av Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 0d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at Funeral Director 1 Yes 2 □ No Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Caddie 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) owendolyn Allen 20a. Method of Disposition 20b. Place of Disposition (Name cemetery, crematory or other 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Garrison 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee win 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physician as attending p IF FEMALE: use If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 🗆 Ectopic pregnancy Month 5 ☐ Other (specify) certificate has been signed by the a rector, page 2 should be detached it 1 ☐ Yes 2 ☐ No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 □Yes 2 No 1 Yes or Attending Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 (Nother (Specify) 1 Yes 2 No Hospital: To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral din 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical and manner stated 29b. Signature and title of certifig 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed (so se of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year,

02

2008

DHMH 17 Rev 1/2001

NO

133

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 8:25 Am Month 8 Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death SOUTH RIVER HEALTH + REHAB EDGEWATER ANNE ARUNDE 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Days unk 63 6-07-1 Usual Residence of Decedent 10a, State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2√ No MD Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 144 Washington Road 21037 USA unk₁₂. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk unk (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) South River Health & Rehab 144 Washington Road Edgewater, MD 21037 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 Removal from State 21. Signature of Funeral Servi 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pheumoni Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause ext. I have the cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): If yes, outcome pf pregnancy 1☐Live birth 2☐ Fetal death 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Month Day Year 4□Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Accident Cerebro vasular 1 Yes 2 No 3 Probably 4 Monknown Seizure disorder 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy Dysphagia. performed? 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Tes 2 No

Physician Medical miner Examiner

Physician /Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

9

Completed

Be ပ

ortant: If item 27 is marked other than "naturar", or items 23a or 28a-f shov injury or other traumatic event, the Medical Examiner must be notified at

permit, Pages 1 and 2 should be filed win Department of Health and Mental Hygien Important: If Item 27 Is marked other thairmetts any injury or other trailmetts.

within 72 hours after death with

Baltimore, Maryland 21215-0036

Hospital or Attending Physician: The law requires that the death certificate be executed and attending physician for the page 2 has certificate

Physician/Medical

Completed by

Be

Certification: To

Medical

Division or Vital Records, P.O. Box 68760

IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

27. Manger of Death

1 Natural

2 Accident

3 ☐ Suicide

4 Homicide

29b. Signature and title of certifier

Other: 4 Volume 15 Residence 6 Other (Specify) 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation

1 ☐ Yes 2 ☐ No 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number

yon. C.

D50653

8-19-2008

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

avan.c. Suranc 5851-Deal 6 church ROUD

Registrar

31. Date filed (Month, Day, Year) 2008 02

6 ☐ Could not be determined

32 Registrar's Signature

within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

death.

		Please Amend PI line	Type or Print in b b PII 25 pe State of Marylan	Black I erME d / Dep	ndelible g883 9/ artment c	Ink. En 4/08 1 of Health	sure All T and Me	Copies ental Hyg	Are Legible	le.	7010
		For State Registrar		Ce	rtificate o	of Death			Reg. No. 2 () ($18 \ 2$	1948
Physicia	an	1. Decedent's Name (First, Middle, Last) Anthon	NoeL		Booke	er	2	2. Date of Dea Month	Day V		e of Death
/Medic	al	4a. Facility Name (If not institution, give s				n, or Location	n of Death	Hugus	4c. County of		
Examine	er _	The Johns Hopkins Ho				ore City	T 04 H 16			B' II - (Ot-	
Funeral Director		5. Social Security Number 220-08-2047 Usual Residence of Decedent	M 2 □ F 7. Age (In yrs. 1	3 Yrs.	Months D	ays Hours		B. Date of Birth (Month, Day	, Year) 985	Birthplace (Sta	land
f show	ō	10a. State 10b. County	49	Jown or L	ocation MOPE						le City Limits Yes 2 \(\subseteq No
a or 28a- be notifie	Direct	10e. Street and Number Pag.	s Avenue	/// -		de ?/2/4	6	1	10g. Citizen of Wh	at Country?	
permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Dispartment of Heath and Mental Hyglene. Important: If them Z1 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at one.	by Funeral Director	11. Manital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U.: Armed Forces? 1 Yes, Give Year or Dates:	S. 13	Was Decedent If Yes, specify	of Hispanic (Cuban, Mexic	Origin? (Speci can, Puerto Ri	ify Yes or No- can, etc.)		American Indian	K.
atural cal Ex	ted	15. Decedent's Edu	cation	16a. Dece	edent's Usual O	occupation	nost of working	, [16b. Kind of Busi	ness/Industry	- 6
the Medi	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4 or 5+)	life.	Paral	ega L	r 2			ZOO	
ed oth	To Be (17. Father's Name (First, Middle, Last)	PC			18. Mo	other's Name	(First, Middle,	Daiden Syrname))	
27 is mark r traumatio	ř	19a. Informant's Nama/Palationship (Ty)	F-11	19b. Mai	ling Address (S	treet and Nur	mber or Rural Ave	-	er, City or Town, St	ate, Zip Code)	16
y or othe	. 774	20a. Method of Disposition Burial 2 Cremation 3 F 4 Donation 5 Other (Specify)	Comoval from State	Place of Disponenter, fre	position (Name of	of J r place)	9-4	-08	20c. Location - Ci	ity or Town, State	e '
Importar any Inju		21. Signature of Funeral Service License	& Roan		22. Name and A	ddress of Fa	for A	Je B	FUDERA	d 21	217
	. v.	23a. Part 1. Enter the disease, or complishook, or freat failure. List only on	ications that caused the death	h. Do not er	nter the mode o	f dying, such	as cardiac or	respiratory ar	rrest,	Onset a	imate Between and Death
ysician Nedical		firmediate Cause (Final disease or condition resulting in death)	Due to (or as a conseq	ntvacro uence of):	anial ht	emorrha	ig t	14/	EXAMINER	6	days
aminer	ē		Hypertension			0	TON APPROVE	BRY MEDICAL			
sician and burial-transit	cal Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conseq			CERTIFIC	THOWALL				
been signed by the attending physician and should be detached for use as the burial-transit	Physiclan/Medica	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregna 1 Live birth 2 Feta 4 Pregnant at time of d 9 Unknown	al death 3	☐ Ectopic preg				23d. Date Month	-	Year
signed by d be detar		Part II. Other significant conditions con	ntributing to death but not res	sulting in the	underlying cau	ise given in P	art I.	23e. Did to	obacco use contrib res 2 No 3		e of death?
m N	Completed by							24a. Was a autop perfor	sy pri rred? de	ere autopsy find for to completion eath?	of cause of
ficate ha		25. Was case referred to medical				26. Pla	ace of Death (1 ☐ Yes Check only or		Yes 2 No	
r death. ctor: After this certification by the funeral director.	To Be	avaminar?	Hospital: 1 Sepatient 2 -	ER/Outpatie	ent 3 DOA	Othor:			lence 6 🗆 Other	(Specify)	
within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page		27. Manner of leath 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time Injury	of 28c.	Injury at Work? 1 Yes 2		3d. Describe h	now injury occurred	d 	
I Director	Certification:	3 Suicide 6 Could not be determined	28e. Place of injury - At he building, etc. (Specify		treet, factory, of	ffice	28	8f. Location (S City or Tow	Street and Number n, State)	r or Rural Route	Number,
thin 24 hours at the Funeral I	Medical (sician: To the best of my kno iner: On the basis of examina and manner stated.								use(s)
Nithin To the Somple	Mec	29b. Signature and title of certifier	and married stated.	_	29c. Li	cense numbe	er -		29d. Date signed (Month, Day, Yea	ir)
/			~	1.P		RES	-000		Aug	45t29	2008
2		30. Name and address of person who c	14 11 11				600 N	orth Wo	lfe St, Balt	imore, M	D, 21287
Sta Registr	te ar	31. Date filed (Month, Day, Year) SEP 0 2 2008	22. Registrar's Signa	ture 40	the						

08-06359 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Eric J. Brown State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registra 2. Date of Death dent's Name (First, Middle,Last) Physician/ Month Day August 20, 2008 0320 hrs Medical Examiner 0 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Baltimore University Hospital 9. Birthplace (State or If Under 1 Year I If Under 24Hrs. Date of Birth (MM/DD/YYYY) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director Country) 1 X M Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location any 1 Yes 2 or 28a-f show hours after death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country 23a Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Race - American Indian, Black, 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces Never Married 2 Married Yes If Yes. Give Year 4 Divorced Yes 2 No specify: Specify: "natural", ۵ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Busine 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+ 72 permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'injury or other traumatic event, the Medical. Baltimore, MD 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Majden Surname) Be (Street and Number or Rural Route Number, City or Town, State မ 19b. Mailing Address 20c. Location -20b. Place of Disposition (Name of cemetery 20a, Method of Disposition 500 Donnell rematory or other place) Burial 2 Cremation 3 BAltimore Do . Signa ulton Approximate Interval ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hea Physician Inly one cause on each line. Between Onset and /Medical Death a. Gunshot Wound of Head Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and Physician/Medical signed by the attending physician be detached for use as the burial UNPENDED AMENDED e Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis letly filling in by the funeral director, page 2 should be detached for use as the buritelety filled in by the funeral director, page 2 should be detached for use as the burit Box 68760, 23d. Date of delivery IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Ectopic pregnancy Year Live birth Fetal death past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. contributing to death but not resulting in the underlying cause given in Part I. Yes 2 ✓ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed? Yes 2 ✓ Yes 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 / Inpatient 2 DOA Nursing Home 5 Residence 6 Other ER/Outpatient 3 1 ✓ Yes No 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: Aug 19, 2008 Subject shot 1313 hrs Yes 2 V No Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide or Town, State) 1000 blk Edmondson Avenue, Baltimore, MD (Specify) Local Street 4 V Homicide 29a. Certifier 1 (Check only one) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical

To the 1

State Registrar 29b. Signature and title of certifier

DHMH 17 Rev 1/2001 OCME 2006

Assistant Medical Examiner Ling Li, MD 31. Date filed (Month, Day, Year)

, mo

30. Name and address of person who completed cause of death (Item 23a)

2. Registrar's Signature

2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

OCME

29d. Date signed (Month, Day, Year)

August 21, 2008

			For State Registrar	State of Maryl		artment of H rtificate of L		d Mental Hy	/giene .Reg. No.	711110	27950		
	_		Negistrar Necedent's Name (First, Middle, Lass)	t)				2. Date of De	eath _		3. Time of Death		
	Physici		IRENE MARIA BENJA	MTN				Augus	Angust 27 2008 5 12				
- char	/Medic Examin		4a. Facility Name (If not institution, give	street and number)	4	4b City, Town, or	Location of De	ath	4c.	County of Deatl	1		
فأنسه			maryland Gen			Bultima	ce Cri	4					
	Funeral		5. Social Security Number 6. Security Number 1	□M 2NTE	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours Mi	n. (Month, D	ay, Year)	Co	untry)		
	Director		Usual Residence of Decedent	50) 113.			AUG. 1	2, 19	58	MD		
	land ow		10a. State 10b. County	10c	. City, Town or Lo	cation			_		10d. Inside City Limits		
	Mary a-f sh	tor	MD	BA	ALTIMORE						1 X Yes 2 ☐ No		
	or 28.	Director	10e. Street and Number			10f. Zip Code			10g. Citi	izen of What Co	untry?		
	23a	ral	1611 RUXTON AVE.			21216			USA				
	r deg	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of Hi If Yes, specify Cuba	ispanic Origin? ın, Mexican, Pu	(Specify Yes or N erto Rican, etc.)	0-				
36	72 hours after death with the Maryland 'natural", or items 23a or 28a-f show doal Examiner must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	1 ∐Yes 2. KMNo If Yes, Give Year or Dates:		1 □Yes 2 X No	Specify:			Specify: BL	ACK		
21215-0036	hour fural	ed	15. Decedent's Ed		16a. Dece	dent's Usual Occup	ation		16b. Ki	ind of Business/l	ndustry		
75	s 1 and 2 should be filed within of Health and Mental Hygiene. item 27 is marked other than "other traumatic event, I'm Me	Completed	(Specify only highest gra-	de completed) College (1-4or 5+)	(Give	kind of work done of DO NOT use retired	during most of w l)	vorking	1				
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D		Be (17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle	e, Maiden	Surname)			
yla		ုင	LOUIS MUSE					J. PERRI					
Maryland			19a. Informant's Name/Relationship (7	Type. Print)		,			-				
			KEVIN JOHNSON 20a. Method of Disposition	20				Date					
Baltimore,			1 X Burial 2 ☐ Cremation 3 ☐	Hemoval from State		osition (Name of matory or other plac	i i		1				
Ē	permit. Page Department of Important: If any Injury or once.		4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service Licen	#		CARMEL 2. Name and Addres							
B	permit. Departr Importa any Inja		While !	Mark									
			23a. Part 1. Enter the dispace, or companions shock, or heart failure. List only	plications that caused the o	death. Do not en						Approximate Interval Between		
w.nob.	Physician		Immediate Cause (Final disease or condition	Severe	Anoxi	c Ence	phalop	ox 4hy			Onset and Death		
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100	Examiner		Sequentially list conditions.	, Cardiae	HRRES	+							
7	ed sit	ine	Sequentiany liet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a eeg	sequence of):	ory Far	lure.						
V	xecut and II-tran	Examin	that initiated events resulting in death) Last	c. Due to (or as a con		7 7 6							
8760,	cate be executed physician and the burial-transit			,									
687		edical		.u									
Вох	death certifi e attending I id for use as	M/I	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro		☐ Ectopic pregnanc	v				*		
	0 0 0	Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 ☐ Pregnant at time 9 ☐ Unknown		Other (specify)				Month	Day Year		
P.0	requires that the de been signed by the hould be detached	Phy	9 ☐ Unknown Part II. Other significant conditions c		reculting in the	endorlying course six	on in Port I	23e Did	tobacco	use contribute to	the cause of death?		
S,	ires the signe	þ		Farlure	resulting in the c	andenying cause give	en in raiti.						
Ö		etec	7,000.					24a. Wa		3. Time of Death Year 2006 9. Birthplace (State or Foreign Country) 10d. Inside City Limits 1			
of Vital Records,	e la has	Completed						— auto	opsy formed?	County of Death 9. Birthplace (State or Foreign Country) 10d. Inside City Limits 1			
ā	ician: Th certificate ector, pag		25. Was case referred to medical				26 Place of F	1 Yes Death (Check only		1 Yes	2 🗗 No		
>	Physician: r this certific ral director,	To Be	examiner?	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA Oth	or:			6 ☐Other (Spe	cify)		
Jo r	ig Ph ter thi		27. Manner of Death	28a. Date of Injury (Month, Day, Yea	28b. Time o			28d. Describe			- //		
Ö	Attending r death. ector: After by the funer	atio	1 Matural 5 Pending 2 Accident investigation		, , , , , ,		Yes 2□No						
Division	or Atterdeterde	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, st oecify)	reet, factory, office			(Street ar own, State		ural Route Number,		
Ω	Hospital or 24 hours afte Funeral Dir tely filled in		00 0 00 00	T	the state of the			least and bus to the			a atata d		
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical											
	o the vithin 2 o the comple	Me	29b. Signature and title of certifie			29c. Licens	e number		29d. Da	ite signed (Mont	h, Day, Year)		
	- > - 0		· 441	4		89	1613		8	1/27/08			
	1		30. Name and address of person who	completed cause of death	(Item 23a) (Type,		. 0	. 6 /	/	1 1			
	1			55a, M.J.	10 11	/aryland	been	eral X	OSPI	top			
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	9,1							
	Regist	ar	SEP 0 2 2008	JURIEU D	- Marie	See See See See See See See See See See							

Registrar DHMH 17 Rev 1/2001 08-06137 Patricia Kay Brown Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

2008 27951

		For State		Ce	rtificate c	f Death					eg. No.	20		-
Physician/ edical Examine	1.	Decedent's Name (First, Middle Patricia Kay								Date of Dea Month August 11	Day Ye 1, 2008		3. Time of Death 1234 hrs	
f. t.	48	a. Facility Name (if not institution Harford Memorial Hos		umber)		4b. City, To Havre				76.5	4c. County Harford	1		
Funeral Director		Social Security Number 218-70-4772	6. Sex	7. Age (In yrs.	last birthday)	if Under Months		tf Under Hours	Adin		rth(MM/DD/YYY 3, 1958	Y) 9. Bir Foreig Co	rthplace (State or gMaryland buntry)	
	U	sual Residence of Decedent Da. State 10b. County	1 101 221	10c. Cit	y, Town or Loc	ocation 10d. Inside							10d. Inside City Lin 1 Yes 2 X	1
the Maryland a or 28a-f show	Ma 10	aryland Cec	<u>il </u>		Perr	yville 10f. Zip (10g. Citizen of What Country?				
		542 Evan Stre		cedent Ever in	U.S. 13. V	Vas Deceden	1903 t of Hisp	anic Origi	in? (Spe	USA cify Yes or No- 14. Race - American Indian, Black,			-	
ther death with		Never Married 2 N	Armed F 1 Yes vorced If Yes, Give Ye	2X No	ļ.	If Yes, specify Cuban, Mexican, Puerto Rican, 6 1 Yes 2 X No specify:					Specify		nite	
215-0036 be filed within 72 hours after mal Hygiers, reded other than "natural", creat, the Medical Examiner.	nalal	15. Decedent's Education (Spe Elementary/Secondary (0-12)		ade completed) (1-4 or 5+)	during most of working life. DO NOT use retired)							/Industry		
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 Department of Health and Nemal Hygiere. Important: If item 27 is marked other than injury or other transmit event, the Medical Table 1 and 1 an	7	9 7. Father's Name (First, Middle			_ La	aborer	1				Maiden Surnan	-		-
2121 Ild be fi Mental narked event,	0 1	Oscar M. Brow			19b. Mai	Frances Scoseild 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stat							te, Zip Code)	
AD 2 show th and 1 27 is rumatic	-[Betty A. Stan					t. H	avre d	e Grace	, М <i>а</i>	ryland 21	.078		
nore, MD 21214 ages 1 and 2 should be fil nt of Health and Mental It tt: If item 27 is marked other traumatic event,	- 1	20a. Method of Disposition 1 Burial 2 X Crematic	crematory or	osition (Name of cemetery, Date 20c. Location - City or To other place) ematory The 08/28/08 Baltimore,							nd			
Baltimore, permit. Pages 1 ar Department of Hee Important: If ite injury or other tr	2	Donation 5 Other State Signature of Funeral Service	Specify: e Licensee	0.	etro Ci	tro Crematory Inc. 08/28/08 Baltimor remation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryl Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart								
	T	Thomas Gregor	Noman)	Sured the des	ath Do not ente	99 Fred	deri	ck Ro	oad ardiac or	Baltim respiratory a	ore, Ma	ryla heart	and 21228 Approxima e Int	
Physician Medical		failure. List only one caus	e on each line.							100			Between Onset Death	t and
aminer		or condition resulting in death)	Due to (or as	a consequence	e of):									
	ווס	Sequentially list conditions, f any, leading to immediate cause. Enter Underlying Cause												
led nsit		(Disease or injury that initiated events resulting in death) Last	Dura ta Jan as	a consequenc										
760, crate be executed physician and the burial - transit	Medical	X UNPENDED	AMENDE	PI 13	ne a-b	, 2/,	per	EM g	883	9.11.08 TT				
		IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (Specify)										ır		
that the deatled by the att	Physician	1 Yes 2 ✔ No 9 U		to death but n	ot resulting in t	ne underlying	cause g	given in P	art I.	23e. Did	tobacco use co	ontribute	to the cause of deati	th?
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cords law requ has been	Completed									pe	topsy rformed?		to completion of caus ?	
tal Rection: The certificate ector, page		25. Was case referred to medi	cal				26.Place	of Death	(Check					
Vita hysicia r this ce	To Be	examiner? 1 ✓ Yes 2 No	Hospital:		✓ ER/Outpat		28c Iniu	Other ₄		ng Home 5	Residence		her:	
on of Vital I tending Physician: eath. or: After this certifi			ending vestigation	ate of Injury onth, Day,Year)	Zop. Time	Of Ingury		Yes 2	_					
Division spital or Attendin hours after death.	Certification	3 Suicide 6 Co	ould not be stermined (Special	lace of Injury - A	At home, farm,	street, factor	, office t	ouilding, e	etc.		n (Street and Nu n, State)	ımber or	Rural Route Numbe	л, City
	Medical C	29a, Certifier	Physician: To the l xaminer:On the bas and manne	sis of examination	vledge, death o	ccurred at the	e time, d y opinior	ate and p	lace, and	d due to the cat the time, da	ause(s) and mar ate and place, a	nner as s	tated. the cause(s)	
or wi	Me	29b. Signature and title of cert		1 000		29	o. Licens	se numbe .M.E.	r		29d. Date s		Month, Day, Year) 08	
×	-	30. Name and address of pers Pamela E. Southall,		ause of death (111 Penr	n Stree	et, Balti	more, I	MD 21201				
Sta		31. Date filed (Month, Day, Yes	ar) 32	Registrar's Sig		and i								
Regist		SEP V 2	, 2000 /21	162.1	ORIG	NAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Z9H ZOC8 **Physician** August 0654AM Herbert F. Behrens /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8. Date of Birth (Month, Day, June 12, HOSPITAL 6. Sex 7. Age (In AGNES Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 F Months Days Ĩ′929 79 Director 220-20-2772 Maryland Usual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Wedical Examination roughts notified at Director 1 ☐Yes 2K No Marvland Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 USA 715 Maiden Choice Lane PV311 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. 1 XYes 2 No
If Yes, Give Year or Dates: 1952-54 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔼 No Specify \$ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) i be filed within 7 intal Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, train any once. Elementary/Secondary (0-12) College (1-4or 5+) 12 US Government Investigator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Herbert F. Behrens Dorothy Link ဥ Pages 1 and 2 should 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wife Beverly Behrens 715 Maiden Choice Lane PV311; Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) New Cathedral Cem. 9-2-2008 Baltimore, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 21. Signature of Funeral Service Licen 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 1630 Edmondson Avenue; Catonsville, MD 21228 Approximate Interval Between Onset and Death Immediate Cause (Final carde **Physician** disease or condition resulting in death) /Medical Due to (or as a consequent of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Physician/Medical Examiner that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): Records, P.O. Box 68760, physician use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) been signed by the a 1 ☐ Yes 2 ☐ No 9 Unknown Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 certificate Vital 1 Nes 2 □ No 1 Yes 2 No or Attending Physician; funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To After this ð 27. Man of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 ☐ Accident after death filled in by the 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier (Check only one)

Division To the Hospital within 24 hours a To the Funeral C Hospital completely Registrar

Behrens,

DHMH 17 Rev 1/2001

State

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

ORIGINAL

DO4964

900 CATONAVE BALTIMORE, MO 21229

and manner stated.

MD

Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1AM J. HICKEN

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			For State Of Maryland / Do	Certificate of Death		eg. No.	8 27953			
Н	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Deat Month	Day Year	3. Time of Death			
١.,	/Medi		Rose K. Brizendine 4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	Augus	4c. County of Death				
أمي	Examir	er	Seasons Hospice	Randallstown		Baltimo				
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birth	Months Days Hours Min	8. Date of Birth (Month, Day,		thplace (State or Foreign ountry)			
	Director		212-12-2267 1	S. Hours War.	Jan 7, 1	1914 Te	xas			
	yland now		10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits			
	a-f st	ctor	MD Balt:	lmore			1 TYes 2 No			
	or 28	Dìre	10e. Street and Number	10f. Zip Code	10	og. Citizen of What Co	ountry?			
	s 23a	by Funeral Director	1500 Bedofrd Avenue #409	21208		USA				
(0	fter de	Fun	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Never Married 2 □ Married 1 □ Yes 2 ሺ No	 Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit				
036	ral", o	l by	3 🖾 Widowed 4 □ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 █ No Specify:		Specify: wh	nite			
5-0	"natu	letec	(Specify only highest grade completed) (0	ecedent's Usual Occupation Give kind of work done during most of work	king	16b. Kind of Business	/Industry			
12	withir iene. • than	Completed	Elementary/Secondary (U-12) College (1-4or 5+)	fe. DO NOT use retired) housewife		wn home				
b	al Hyg other	Be C	17. Father's Name (First, Middle, Last)		ne (First, Middle, M					
ylaı	should be filled within 72 hours after death with the Maryland and Mental Hygiene. It marked other than "natural", or items 23a or 28a-f show umatic event, the Medical Examination is use the righting at	To E	Barney Klubock	Clara E	ingrust					
Mar	12 sho h and 7 is m traum	ė ni	19a. Informant's Name/Relationship (Type. Print) 19b. M Barry Finglass/son 23	ailing Address <i>(Street and Number or Ru</i> 08 Sugarcone Road E	ral Route Number,	City or Town, State,				
<u>.</u>	1 and Healt tem 2	1		sposition (Name of		, MD 2120 20c. Location - City or	-			
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Michael Event for the traumatic event, the Michael Event for the profitted at once.		1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Cther (Specify)	crematory or other place)						
Balt	permit. Depart Import any inj once.		21. Sign were fineral Stylice Licensee Made Director	22. Name and Address of Facility State Anatomy Board	1 655 W.	— Baltimore	Street			
Н			23a. Part 1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	Baltimore MID 2120	11		Approximate Interval Between			
Z,	Physician		Immediate Cause (Final				Interval Between Onset and Death			
and the	/Medical Examiner		Due to (or as a consequence of)							
H	LAAIIIIICI	<u>-</u>	Sequentially list conditions, If any leading to immediate	IP FRACTURE						
	uted d ansit	Examiner	Sequentially list conditions, if any, learning to him reduct cause. Enter Underlying Cause (Disease or injury that initiated events		N	CW FRUM				
oʻ	e exec ian an irial-tri		resulting in death) Last C	W	LED BY WELL					
68760,	The law requires that the death certificate be executed atte has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	ledical	d	000	M WENGED BY WENG					
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Box	death cer e attendir d for use	Physician//	in the past 12 months? 1	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of de Month	livery Day Year			
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S,	v requires that the de been signed by the should be detached	ρ	Part II. Other significant conditions contributing to death but not resulting in the	e underlying cause given in Part I.		acco use contribute to				
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He He	The law cate has page 2 (Completed			24a. Was an autopsy perform	prior to	utopsy findings available completion of cause of			
		e)	25. Was case referred to medical	26. Place of Deal	1 ☐ Yes 2 th (Check only one	•	2 I M6			
o	Physician: r this certific ral director, p	ව ව	examiner? 1 Pres 2 No Hospital: 1 Inpatient 2 ER/Outpa	Othors		nce 6 Other (Spe	ecity) HOSPICE			
ָ מר	ung P	ÖÜ	27. Manner of Death 1 □ Natural 5 □ Pending 28a. Date of Injury (Month, Day, Year) Inju	y Work?	28d. Describe hov		HOSPICE			
Division	death death ctor: y the	licat	2 Maccident investigation 3 Suicide 6 Could not be determined determined		Swojed	•	um I Davida Alumbay			
2	al or / s after il Dire	Certification	4 Homicide building, etc. (Specify)	me	City or Town,	eet and Number or Ri State)	eford Ave			
:	io the hospital or Attending Physician: In the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier (Check only (C	eath occurred at the time, date and place	and due to the ca	use(s) and manner a	s stated.			
	vithin (Medical	one) and manner stated. 29b. Signature and title of certifie	29c. License number		d. Date signed (Mont				
	1.0		Ilelyan Dien	H45931						
			30. Name and address of person who completed cause of death (Item 23a) (Ty	•	2	. 1. 1	7th 2008 MD 21136			
	Ch		31. Date filed (Month, Day, Year) 32. Sgistrar's Signature	THET SUITE 20	0 1445	TORSTOWN	MD 21136			
	Stat Registra	٠	SFP 0.2. 2008	Goseli						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month monst 2000 Frances Baierlein /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Medical ('onler nlo If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🂢 F Year Months Yrs. 213-36-5907 Director 70 Feb. PA Usual Residence of Decedent death with the Maryland 10a. State artment of Health and Mental Hygiene.
ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show
injury or other traumatic event, Inc Provided Examiner must be notified at 10b County 10c, City. Town or Location 10d. Inside City Limits Director Anne Arundel Glen Burnie 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7867 Crilley Road Apt. 492 Funeral USA 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No Be Completed by 3X Widowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Bright ပ James В. Betty Jane Orwig 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Patricia Mayo Daughter 602 Hamilton Place Glen Burnie, MD 21061 permit. Pages 1 an Department of Heal Important: If item 2 any injury or other 20b. Place of Disposition (Name of commetery, crematory or other place)
Atlantic
Crematory, LLC 20a, Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Glen Burnie, MD 21061 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation S.W. Glen Burnie, MD 21061 M00918 Svs. 1 2nd Aven. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to enter Underlying cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence or) the Hospital or Attending Physician: The law requires that the death certificate be executed burial-trans and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical as the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Completed 2XINo 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy certificate 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Manner of Death Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA After this funeral Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Natural Accident death. 1 ☐ Yes 2 No after death Director: 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year)

DHMH 17 Rev 1/2001

State Registrar

10

Name and add

31. Date filed (Month, Day,

Year)

person who completed cause of death (item 23a) (Type, Print)

32. Registrar's Sig

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year Burton MARTHA W 2035 PM 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTILLAL Voar | If Under Baltimore University 6 MATLIAMO 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 M 2 1 F Months Days Hours Feb 8, Director 283-42-9993 1961 Ohio Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or Items 23a or 28a-f show dical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Lutherville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? within 72 hours after death with 21093 19 Dickens Square USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🔀 No 2 3 Widowed 4 Divorced Specify. White Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) 12 Research Chemist Medical 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stephen н. Burton Mary Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leland Burton/Brother 3752 Waterstone Court, Amelia, Ohio Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🗓 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cincinatti, Ohio Spring Grove Cemetery 8/23/08 22. Name and Address of Facility 21. Signature of Furniervice Lemmon Funeral Home of Dulaney Valley Inc. Michael J 10 W. Padonia Road, Timonium, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** montus disease or condition resulting in death) Sound cell /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-tran resulting in death) Last Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, Physician/Medical attending pl 23c. If yes, outcome pf pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Year 4□Pregnant at time of death 5 ☐ Other (specify) 9☐Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 1 ☐ Yes 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No page 2 s certificate has autopsy perform 1 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death Check onl o e 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA 1 ☐ Yes After this 27. Manner of Feath 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred Natural 2 Accident 5 Pending investigation (Month, Day 1 ☐ Yes 2 ☐ No after deat 6 Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in 3y 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only one) 29b. Signature and title of certifier 29c. License number 1598967499 140 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) S 54. Ce reene BALtinne MA 21201 FRIC 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

ian	 State Registrar Decedent's Name (First, Middle, L 	ast)		Certificate of L	Jean	2. Date of Deat		3. Time of Death		
	Elizabeth A. B	rand				Month August	31, 2008	04:00 A M		
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			(In yrs. last birtho	(ay) If Under 1 Year	If Under 24 Hrs.	8. Date of Birth (Month, Day,	9 B	irthplace (State or Foreig		
	216-46-3047	1□ M 2🌠 F	90 Yrs	Months Days	Hours Min.	June 13		nio		
	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o	r Location				10d. Inside City Limits		
Director	Maryland Baltin	nore	Tow	son				1 ☐ Yes 2 🔀 No		
ē	10e. Street and Number			10f. Zip Code		1	0g. Citizen of What 0	Country?		
<u></u>	1055 W. Joppa Re	nad		2120	14		USA			
Funeral	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - An			
To Be Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	If Yes, Give 25	0	If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	Specify:	rican, etc.)	Black, Wh			
ted b	15. Decedent's 8	Year or Dates:	16a. D	ecedent's Usual Occup	ation	I	16b. Kind of Busines	hite s/Industry		
ble	(Specify only highest g Elementary/Secondary (0-12)	rade completed) College (1-4or 5+	`/i	Rive kind of work done of fe. DO NOT use retired	furing most of work ()	ing				
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မ	Edward 19a. Informant's Name/Relationship	(Type, Print)	Resch	lailing Address (Street	Lucy and Number or Bur	al Route Number	Monre			
	Barbara Brand/Da		7	Sawgrass Co	urt. Tim	onium. M	larv1 and	21093		
-	20a, Method of Disposition	augitei		sposition (Name of crematory or other place		Date	20c. Location - City of			
	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		1	crematory or other place Valley Mem	10101		Timonium	, Maryland		
	21. Signature of Funeral Service Licensed 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley Inc.									
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ļ, ķ	shock, r heart Filure. List onl Immediate Cause (Final	y one caus on a ch line		mie h	o-at N	10000	(9)	Interval Between Onset and Death		
	disease or condition resulting in death)		consequence of):	me 1				years		
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	resulting in death) Last	Due to (or as a	consequence of):							
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	IF FEMALE:		,							
ian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of	☐ Fetal death	3 ☐ Ectopic pregnanc	y		23d. Date of o	lelivery Day Year		
Physician/	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 ☐ Pregnant at 9 ☐ Unknown	time of death	5 C Other (specify)			World	Bay Tour		
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Be Completed	25. Was case referred to medical examiner?	Hospital:		Oth	26. Place of Deat	perfori 1 □ Yes h <i>(Check only on</i>	med2 death 2 No 1 Ye	PLAKE hove		
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DHMH 17 Rev 1/2001

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

			1 - For State Registrar	State of	f Maryland	•	artment of		nd Me		ene 0 0	8 27957	
	4 1 1	, T	Decedent's Name (First, Mide	dle, Last)				-	2.	Date of Death Month	1	3. Time of Death	_
	Physici /Medic		Bruce C.	Burnett					A		24, 2008	M. M.	
	Examin		4a. Facility Name (If not instituti	on, give street and num	nber)		4b. City, Town	n, or Location of	Death		4c. County of	Death	
A		<u> </u>	Carroll Hos			and birds value	West If Under 1 Ye	tminster ar If Under 2		Data of Righ	Carı	oll	
	Funeral Director		5. Social Security Number 214-54-7311	6. Sex 1 X M 2 ☐ F	7. Age (In yrs. I.	ast birtnday) Yrs.	Months Day		Min.	Date of Birth (Month, Day, uly 6,	Year) 9.	Birthplace (State or Foreign Country) MD	
			Usual Residence of Decedent							ary 0,	1747	TID	_
	inylan ihow		10a. State 10b. Coun	ry	10c. City	, Town or Lo	cation					10d. Inside City Limits	
	8a-f	Director		arroll	T	aneyto						1 Yes X No	
	with the	Dire	10e. Street and Number	D . 1			10f. Zip Cod			10	g. Citizen of Wha	-	
	ne 23	Funeral	6 Starboard		dent Ever in U.	S. 13.	Was Decedent	21787 of Hispanic Orig	in? (Specif	v Yes or No-	US 14. Race -	American Indian,	-
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "natural", or Iteme 23a or 28a-f show myning or other traumatic event, It a Medical Exemple mainten militar at DDE8.	þ	1 ☐ Never Married 2 ☑ Ma 3 ☐ Widowed 4 ☐ Divorce	If Yas Giv	2 □ No re	į	lf Yes, specify C 1 □ Yes 2 🗓 i	of Hispanic Orig luban, Mexican, No Specify:	Puerto Ric	ćan, etc.)	Specify:	White, etc. White	
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Baltimore,	Pages nent of h		1 N Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		State		alley M	1	8/29/	′08 ′	Timonium	, MD	
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	Physician /Medical		23a. Part: Enter the disease, shock, or heart fature. List immediate Cause (Final disease or condition resulting in death)	or complications that c st only one cause on e a	aused the death	Do not ent	er the mode of d	tying, such as o		espiratory arre	st,	Approximate Interval Between Onset and Death	
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K 68	ertifica ling pl	Med	IF FEMALE:	20.14		•							19
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Records,	w require been sig should b								_	1 🗌 Ye	s 2 🗆 No 3	Probably 4 Unknown	
000	e law re has bee je 2 sho	plet								24a. Was an		re autopsy findings available or to completion of cause of	
	The ate his page	Completed								perform	ed?/ dea	ith? IYes 2 No	
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6	after I Dire	Certification:	4 Homicide	buildir	ng, etc."(Specify	1)				City or Town,	, State)		
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į	X		30. Name and address of person	n who completed caus	e of death (Item	23a) (Type,		1	20-1	*	15 2		
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		1 Decedent's Name (First, Middle, Last) 2. Date of Death									3. Time of Death		
Physici /Medic		DULULIA L. DULIS									1:45 P M		
Examin		, ,						4b. City, Town, or Location of Death			4c. County of Death Baltimor		
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and w		Usual Residence of 10a. State	Decedent 10b. County		10c. Ci	ty, Town or L	ocation						10d. Inside City Limits
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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Evantical must be rediffied at one.	þ	11. Marital Status1 ☐ Never Marrie3 ☒ Widowed		Armed For	ces? 2 X No re		Was Decedent of If Yes, specify Control of Image of the Image of			Rican, etc.)		Black, White	
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Pages nent or ant: If i			☐ Cremation 3 5 ☐ Ø ther (Spe	☐ Removal from S	state i	'kwood C		lace)	9/4/2	008	Parkvil	lle Ma	ryland
permit. Departr In porta any inju		21. Signature of Fu	neval Service A	ensee Live	ln		22. Name and Add		•	, Inc. 10	050 York	c Road	21204 Towson, Md.
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Physician /Medical Examiner		disease or condition resulting in death) a. Due to (or as a consequence of):										Merviss	
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent in the past 12 1 □ Yes 2 D 9 □ Unknown	months?		oirth 2 🗍 Fet nant at time of	al death 3	☐ Ectopic pregna ☐ Other (specify)				23d	. Date of de Month	elivery Day Year
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: The law I cate has b page 2 sh	Completed									24a. Was auto perfo 1 □Yes		prior to death?	utopsy findings available completion of cause of
sician certifi irector	Be	25. Was case referrexaminer? 1 ☐ Yes 2 😿		Hospital:	Inpatient 2	T EB/Outpoti	ant 3 🗆 DOA	Other:		n <i>(Check only o</i> me 5 ☐ Resi	<u> </u>	Anthor (Co.	ecify) Wospiù
iding Phy th. : After this funeral d	tion: To	27. Manner of Death		28a. Date (Mont		28b. Time Injury	of 28c. Ir	njury at /ork? □Yes 2[28d. Describe			sully)
al or Atter s after dea' I Director d in by the	Certification:	3 ☐ Suicide 4 ☐ Homicide	6 Could no determin	28e. Place	of Injury - At h		treet, factory, offic	e			Street and N wn, State)	lumber or R	Rural Route Number,
e Hospita 24 hours e Funera	ledical C	29a. Certifier (Check only one)		Physician: To the caminer: On the band man									
To the To the Comp	Me	29b. Signature and	title of certifier	1200			29c. Lice	ense number	r 1 <i>0</i> 2		29d. Date s	igned (Mon	th, Day, Year)
		A	van	vm)			1 100	1850	5	/	nugust	29	2008
1,0		30. Name and addr	ress of person w	no completed caus	e of death (Ite	7.0/	Print) CU	who	St.	787W502	V W)	
Sta Registi		31. Date filed (Mon		32. R	egistrar's Sign	ature	le						

8/29/08 1145 P Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death myear Month **Physician** 6:27 A M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** SECAURS 70N BALTIMONE MIDINA NIA DIPITAL 8. Date of Birth Month, Day, Feb 2 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) Usual Residence of Decedent 10b. County city, Jown or Location 10d. Inside City Limits 10a. State 1 Yes 2 □ No Director timore 10f. Zip Code 10g. Citizen of What Country Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married 1 ☐ Yes 2 No ģ 0 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) Completed 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry College (1-4or 5+) illier's Name (First, Middle, Last) Be 10501 ၉ Rural Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number nformant's Name/Relationship (Type 20b. Place of Disposition (Name of 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 5 ☐ Other (Specify) 4 Donation 21. Signature of uneral Service icensee Farri. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, lock, or the art failure. List only one cause on each line. Approximate Interval Between Onset and Death truor diate Cause (Final di ease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Ŭnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2 ☑No iasi 24a. Was an autopsy 2 Z No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 1 No 1 Dinpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

requires that the death certificate be executed P.0. Division of Vital Records,

Physician /Medical

Examiner

physician and s the burial-trans use as 1 attending p for use as

Funeral Director

s been signed by the should be detached certificate has b irector, page 2 st Hospital or Attending Physician: After this c funeral dire within 24 hours after useum.
To the Funeral Director: /

State Registrar

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier HYSICIAN

and manner stated.

1 🖰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29d. Date signed (Month, Day, Year)

ST, BALTIMORE MD 21223

30. Name and ordress of person who completed cause of death (Item 23a) (Type, Print) TIMORE

31. Date filed (Month, Day, Year)

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** AUGUST30 04.50PM Mary C. Comer 2008 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner BALTIMORE HOSP AGNES n/a If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Social Security Number 6. Sex 7. Age (In yrs. last birthday **Funeral** Days Hours 1 □ M 2 🔀 F 84 April 19, 1924 Director Maryland 218–18–5528 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, If a Medical Examinar must be notified at any injury or other traumatic event, If a Medical Examinar must be notified at any once. 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 XYes 2 □ No Directo n/a Maryland Baltimore 10g. Citizen of What Country? 10e. Street and Number United States 21230 1705 Letitia Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ∐ Yes 2 M No If Yes, Give Year or Dates: 1 ☐ Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 ☑ No Specify. Specify. 2 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Wholesale Food Produce 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Polly (unknown) Thomas Lett ျှ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1705 Letitia Avenue, Baltimore, Maryland 21230 Charles E. Comer / Husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Loudon Park Cemetery 9/3/2008 4 Donation 5 ☐ Other (Specify) Baltimore, Maryland 22. Name and Address of Facility Hubbard Funeral Home, Inc. 21. Sine ture of Funeral Service Lice See 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Immediate Cause (Final **Physician** hermonio disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner effection à lung collapse alaphenmente Se uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner burial-transi and requires that the death certificate be exec resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical the use as IF FEMALE: Box 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 3 Ectopic pregnancy Year detached for Month 5 Other (specify) 1 ∐ Yes 2 No 9 Unknow ģ 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by Records, 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page perform 1 ☐ Yes 2 ☐ No 1 □ Yes Vital 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one, Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Hepatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To of Manner of Death Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Hospital or Attending 1 Natural 2 ☐ Accident Division 5 Pending investigation n 24 hours after death.

e Funeral Director: Af 1 🗆 Yes 2 🗌 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely (Check only one) and manner stated. To the within 2 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier AUG 30 2008 CHANDRA BUMMA MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMORE, MD CATON AVENUE HOSPITAL 900 AGNES Registrar's Signature 31. Date filed (Month, Day, Year) 32.

DHMH 17 Rev 1/2001

State Registrar

OMER

2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Angust 3:30 **Physician** Roy Lee Coppadge /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Washington Med. Ctr. Anne Arundel Glen_Burnie If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1**√**M 2□F Days Hours Director 579-42-6883 Feb. 6, 1934 OK Usual Residence of Decedent 10c. City. Town or Location 10d. Inside City Limits 10a. State 10b. County 1 ☐ Yes 2X No Director MD Anne Arundel Glen Burnie 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 605 Elizabeth Rd. 21061 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1★ Yes 2 □ No If Yes, Give Year or Dates: 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2/DoNo Specify: White Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) <u>Senior Contracting Specialist</u> Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any injury or other traumatic ev Raney Coppadge <u>Zula Garrett</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Elizabeth Rd., Glen Burnie, MD 21061 Mrs. Mary Pat Coppadge/Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition September 1 ₩₩Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2008 Elkridge, MD Meadowridge Mem. Pk. 21. Signature Juneral Spric Licensee 22. Name and Address of Facility Singleton Funeral and Cremation du M01411 2nd Ave. SW, Glen Burnie, MD 21061 Services 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death arkinsons Disease Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate bause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit the death certificate be executed Exam Due to (or as a consequence of) attending physician Physician/Medical the as nse 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ned by the atter e detached for u in the past 12 months? Month 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9□Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? page 2 should be de 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed certificate 2 NO Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 th No 1 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dir 27. Mann of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Watural 5 Pending investigation (Month, Day Year) Injury М 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

or Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Year)

29c. License number

29d. Date signed (Month, Day, Year) D65314 August 27, 200 Nospital Drive, GenBurge

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 301 George E. Willes

2008

SEP 02

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend #5, perFH G883 9/11/08 TT

State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

Reg. No. 2008 1 - For State Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) September 1, 2008 **Physician** 3:17P M Kenneth Franklin Durham Jr. /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Randallstown Randallstown Genesis | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | March 3, 1936 Birthplace (State or Foreign 5. Social Security Number 6440 0 7. Age (In vrs. last birthday) **Funeral** Months Maryland 1**X** M 2□ F 72 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinet mast be neatiled at once. 1 ☐ Yes 2 X No Director Owings Mills Baltimore Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 121 South Ritters Lane 21117 Funeral 12, Was Decedent Ever in U.S.
Armed Forces?
1 Yes 2 No 1955
If Yes, Give
Year or Dates: 1961 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. 1 ☐ Never Married 2 ☐ Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify. 2 3 ☐ Widowed 4 🏋 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Real Estate Agent Real Estate 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Henrietta Elizabeth Anderson Kenneth Franklin Durham Sr. ೭ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Barbara Towle, Sister 121 South Ritters Lane Owings Mills, MD 21117 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 09/02/08 Baltimore, Maryland Metro Crematory Inc. 4 □ Donation 5 □ Other (Specify) Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 21. Signature of Funeral Service Licensee Thomas Gregor Mmos 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner Cause (Disease or injury that initiated events resulting in death) Last the Hospital or Attending PhysIclan: The law requires that the death certificate be executed and burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Year Month Day 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 400 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 2 No 1 TYes 2 🗆 No 1 ☐ Yes r this certifice 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 1☐ Yes 2 No 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA in 24 hours after usum.
the Funeral Director: After this of moletely filled in by the funeral director. Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 Natural 28c. Injury at Work? 5 ☐ Pending investigation 1 ☐Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical within 2 To the 29c. License number

1PH D0056414 9-2-2008

Depenint)
Fushing Avenue, Calonsville, MD
2122 29d. Date signed (Month, Day, Year) 29c. License number 29b Signature 32. Registrar's Signature 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

Registrar

08-06676	
William Deter	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2008 27964 1- For State Certificate of Death Reg. No. Registrar 2, Date of Death Decedent's Name (First, Middle,Last) Physician/ Month Day August 31, 2008 William J. Dieter 2205 hrs Medical Examiner 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore County** Northwest Regional Hospital Randallstown 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Maryland
Country 4-8-1955 219-74-9374 Min Director 53 Months Davs Hours 1X M 2 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location Woodlawn MD Baltimore 1 Yes 2 XNo 28a-f show s 23a or 28a-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 7206 Chippenham Place Apt. USA 21244 靣 Funera 14. Race - American Indian, Black, 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married Yes White .. Pages 1 and 2 should be filed within 72 hours after thement of Health and Mental Hygiene, tant: I fitem 27 is marked other than "natural", or other traumaite event, the Medical Examiner. Specify: Widowed Divorced If Yes, Give Year Yes 2X No specify: ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Disabled Disabled 21215-0036 6th 18.Mother's Name (First, Middle, Maiden Surname)
Elizabeth Baldwin 17. Father's Name (First, Middle, Last) Baldwin Harry Dieter 19a. Informant's Name/Relationship (Type, Print) sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 220 S. Clinton St., Baltimore, Itimore, MD Joyce Dieter 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place)
Oaklawn 9-4-2008 Baltimore, MD 1 XBurial 2 Cremation 3 Removal from State permit. Pages Department of Important: II Donation 5 Other Specify Zannino Jr. PH 22. Name and Address of Facility ress of Facility Joseph N. Zannino Jr Conkling St. Baltimore, MD 21. Signature of Fuperal Service Licensee 263 S. see or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart cause on each line. Cardiac arrhythmia associated with renal disease, Approximate Interval 23a. Part I. Enter the disea Physician failure. List only one /Medical Death aenlarged heart, & Atherosclerotic cardiovascular diseas Immediate Cause (Final disease ⁻xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last - transit The law requires that the death certificate be executed AMENDED 23a,27,perME, g884 10/8/08 TT Item#1,as notated,perME,G883,9/2/08,WS Physician/Medical X UNPENDED ned by the attending physician detached for use as the burial Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d. Date of delivery 3 Ectopic pregnancy Year Live birth Month Day Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Ö Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Δ. 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed Records, peen s 24a. Was an 24b. Were autopsy findings available autonsy prior to completion of cause of certificate has performed? death? Yes 2 1 V Yes director, To the Hospital or Attending Physician: 26 Place of Death (Check only one) 25. Was case referred to medical Division of Vital Be examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 After this 1 V Yes No 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of Injury Certification: within 24 hours after death.

To the Funeral Director: A completely filled in by the fur 1 X Natural 1 Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide or Town, State) determined (Specify) Homicide 29a. Certifier 1 Certifying hysician: to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated **Medical** Medical/Examiner or/the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29b. Signature and title certifie 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E September 1, 2008 30. Name and addless of person who completed cause of death (item 23a) Mary G. Ripple MD. Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201

OCME

DHMH 17 Rev 1/2001 OCMF 2006

31. Date filed (Month, Day, Year) State

37. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day August 25, 2008 4:35 P Raymond John Dombrowski 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Harford Bel Air 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Months Days Hours Min 1 □XM 2 □ F 79 July 3, 1929 191-20-1786 Pennsylvania Usual Residence of Decedent 10d. Inside City Limits 10h County 10c. City. Town or Location 10a State 1 ☐ Yes 2X No Maryland Harford Bel Air 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 612 Wendellwood Drive 21014 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian. Was Decedent Ever in 0.3. Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: 1951-53 Black, White, etc. 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify. 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Public School Teacher 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Andrew (NMN) Dombrowski Karlina (NMN) Dombrowska 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 612 Wendellwood Drive, Bel Air, Maryland, 21014 Esther J. Dombrowski / wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Doyation 5 ☐ Other (Specify) 3 Removal from State Bel Air Memorial Gdn. 8/29/2008 Bel Air, Maryland 22. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, Maryland, 21014 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Failure to thrive disease or condition resulting in death) Due to (or as a consequence of): Metastatic pancreatic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year Day 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 HUnknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? fibrillation 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☑ No 1 ☐Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 1 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident

burial-trar physician the attending pl the signed by I page 2 should has certificate

Physician

/Medical

Examiner

Director

Funeral

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Completed

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Funeral

Director

ortant: If Item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the "modical Example," and the modified at

2 should be filed within 72 hours and Mental Hygiene.

Is marked other than "natural",

permit. Pages 1 and 2 Department of Health s Important: If Item 27 is any injury or other tra

Physician

/Medical

Examiner

Physician/Medical Completed Be Certification: To

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

within 24 hours after death

To the Funeral Director:
completely filled in by the the

> State Registrar

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier til asai

SEP 02

6 ☐ Could not be

00063420

August, 25, 2008

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

n. D. 500 Upper Chesaparko Drive Bel Air, mo 21014 31. Date filed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Lomend 9,10e,11,15,16a-b,17,18,19a-b,20a-c,22,peffH g883 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day James Devogelaere /Medical August 18. 2008 4:02 PM 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death 2 Dutrow Court Baltimore Baltimore If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth Sept 8, 1933 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1₩ 2□F 74 Director 213-36-8043 Belgium Usual Basidence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location "naturel", or iteme 23a or 28e-f ehow edical Examiner must be notified at 10d, Inside City Limits MDBaltimore Director Baltimore 1 ☐ Yes 2√ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? e filed within 72 hours after death with 1 at Hygiene.
I other then "naturel", or Iteme 23a or 2 vent, the Medical Examination must be in 2 Dutrow Court Apt. 1B 21237 USA Funera -unic 12. Was Decedent Ever in U.Sunk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Armed Forces? 14. Race - American Indian Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 X Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 🌠 No Specify: Completed by Specify: 3 ☐ Widowed 4 ☐ Divorced white 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry unk Elementary/Secondary (0-12) College (1-4or 5+) unk 4 Engineer Medical treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be unk 8 unk and Mentai 2 Hilaere Devogelaere Yvonne Patenaude 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code unk Ron Varlotta (personal I Baltimore County Police Rep.) 9771 Diversified Lane Ellicott City, MD 21042 Health tem 27 Item 2 other Baltimore, 20a. Method of Disposition
1 ☐ Bunal 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 Department of Important: if eny injury or sonce. Bayview Crematory Inc. 9/12/2008 Baltimore, MD 4 Donation -5 Dina (Specify) in state 21. Signature of Euneral Service RODA C22 Name and Address of Factory Bruzdzinski, F.H. 1407, Old Eastern Ave. Essex, MD 21221 man Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or As a insettuence of) Examiner Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed for use as the burial-transit that initiated events resulting in death) Last Due to (c ettending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 4☐Pregnant at time of death Day 5 Other (specify) P.O. detached 9 Unknown ۵ sete hes been signed page 2 should be det Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ 2 No Be Completed 1 🗌 Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 2 1 Yes efter death.

Director: After this certifice in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No ျှ Other: 4 Nursing Home 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Day Year) Manger of Death Certification: 28b. Time of 28d. Describe how injury occurred or Attending Natural 5 Pendina investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) efter Direc 4 Homicide filled Within 24 hours e To the Funerel C the Hospital Medical 29a. Certifier (s) and manner as stated. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 31. Date filed (Month, Day, Year, Registrar's Signature State Registrar SEP 0 2 2008

		•	State amend #	2 Per DVR	G883 9/02/	tificate of l	Death	Re	g. No.			
	Dharaisi		1. Decedent's Name (First, Middle, Las	st)				2. Date of Death Month	Day Year	3. Time of Death		
	Physicia /Medic		Julia C. Drex	ler				Septem		12:45p ^M		
	Examin	er	4a. Facility Name (If not institution, give				Location of Death		4c. County of Death			
			Franklin Wood:			Rose		1	Baltimo			
	Funeral		5. Social Security Number 6. S	□ 14 050 C	(In yrs. last birthday) O 1 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year) 9. Birthp	lace (State or Foreign htry)		
	Director		212-09-3894 Usual Residence of Decedent		91 Yrs.			9/19/1	1916 Mary	yland		
	and		10a. State 10b. County		10c. City, Town or Lo	cation	1		1	0d. Inside City Limits		
	Marylan f show	5	MD Baltin	nore	Dundalk					1 ☐ Yes 2 🔀 No		
	28a	rec	10e. Street and Number			10f. Zip Code		10	g. Citizen of What Cour	ntry?		
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	death ma 2	era	11. Marital Status	12. Was Decedent 8		Was Decedent of H		ecify Yes or No-	14. Race - Americ			
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21215-0036	filed within 72 hours after death with the Maryland Hygiene. uthar than "naturel", or Itema 23a or 28a-f show snt, Ita Medical Evartirer must be nutified at	Completed by Funeral Director	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual Occup	during most of work	ring	16b. Kind of Business/In	dustry		
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Maryland	d 2 si th an 7 ls r traur		Kathleen Ruby	rype, rimi daug					re, MD 21			
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õ	ages nt of t: if it		1 ☑ Burial 2 ☐ Cremation 3 ☐		1	matory`or other plac Hrt.Jes	9/6/	2008 E	Baltimore,	MD		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "naturel", or Itema 23e or 28e-f show any Injury or other traumatic event, It a Medical Examinat must be nutified at once.		*4 ☐ Donation 5 ☐ Other (Specification of Funeral Service Lice)					b N		7		
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<u>α</u>	that the by detact	H.	Part II. Other significant conditions	contributing to death b	ut not resulting in the u	inderlying cause giv	ven in Part I.	23e. Did tol	pacco use contribute to I	the cause of death?		
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	To the Hospital or Attendi within 24 hours after death. To tha Funaral Diractor: A completely tilled in by the tu	Aedicai	one)	and manner sta	ated.							
	To Vitt	Σ	29b. Signature and title of certifier	0 , 1		29c. Licens	se number	.0	9d. Date signed (Month,	Oay, real)		
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	10		30. Name and address of person who		eath (Item 23a) (Type	, Print)	C. ADE	DR	BALTIMUR	E MO		
	· CA		31. Date filed (Month, Day, Year)		ar's Signature	LTIN)	RUAKE	017.	DALITHOF	1		
	Sta Regist			008	ar's Signature	well						

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** MAry S. Duvall 2008 9 4112 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster <u>Carroll Lutheran Village</u> Birthplace (State or Foreign Country) If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9/27/1912 7. Age (In yrs. last birthday) If Under 1 Months 5. Social Security Number 6. Sex **Funeral** Days Hours 1 ☐ M 2KX MD 95 Director 218-01-6636 Usual Residence of Deceder 10d. Inside City Limits 10c. City, Town or Location 10a. State MD 10b. County or 28a-f show Hygiene. sther than "natural", or itsms 23a or 28a-f shov snt, the Modical Examinar must be notified at XXYes 2 No Westminster Carroll Funeral Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code United States 21158 201 St. Mark Way 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes SCONO If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 White 1 ☐ Yes 2☐No Specify: Specify: \$ 3√Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) her home Homemaker 12th permit. Pages 1 and 2 should be filed to Department of Health and Mental Hygie important: if item 27 is marked other till any injury or other traumatic avent, III.s. once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Jenny C Boyer David S. Nickey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4111 Teklen Dr. Westminster, MD 21157 Ethel Fuld(Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition XIX Burial 2 Cremation 3 Removal from State Taylorsville, MD 9/2/2008 4 ☐ Donation 5 ☐ Other (Specify) Taylorsville Cem 22. Name and Address of Facility 21. Signature of Funeral Sep Burrier-Queen Funeral Home and Crematory, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximate shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician Aspratan disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Medical Certification; To Be Completed by Physician/Medical Examiner The law requires that the death certificate be executed physician and es the burial-transi Advance resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) cete hes been signed by the page 2 should be detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 2 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation s after de. ••i Director: Atr 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 24 hours after de **Funersi Direct** letely filled in by t 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only onel within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 2

State

Registrar

30. Name and address of person wh

31. Date filed (Month, Day, Year)

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of death

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Helen Eddv 2:20 PM 28 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Agnes Bartimore Hospital Saint N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. 1 □ M 2 XF Months Days Hours 87 AUG 6 1921 New York 104-12-2666 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10b County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21228 211 Rosewood Avenue, #2 USA Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 □Yes 2X No Specify. Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, I'm I'm anone. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Clerical Higher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Clayton В. Taylor Helen Wright 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arlene Sanders - daughter 25 Winehurst Road, Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/29/2008 4 □ Donation 5 □ Other (Specify) Baltimore, MD 21. Signature of Funeral Service Licensee

Steven H. Williams ²²Chame and Address of Facility of Maryland, Inc. 21228 299 Frederick Road, Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Acute cerebrovascular accident days disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Septic Shock Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner The law requires that the death certificate be executed myocardial attending physician and for use as the burial-tran Due to (or as a consequence of) P.O. Box 68760, retroperitoneal IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 🗷 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by Hypertension 1 XYes 2 No 3 Probably 4 Unknown page 2 should de conditioning 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed? Yes 2 No 2 No 1 ☐ Yes or Attending Physician: completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 ■ npatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation s after death, 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only and manner stated. within 2. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier mighter Wang, M.D. P 23496 August 28, 2008 O 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore 900 Canton Ming-Hsi Wang AVENUR 31. Date filed (Month, Day, Year) 32. Pagistrar's Signature 2008 Registrar SEP 02

08-06505			or Print in Black Inde						
Wilbert Michael		1- For State	of Maryland / Departi Ce <i>rtif</i>	ment of He <i>icate of De</i>		ental Hygiene	Reg. N		08 2797
Physicia Medical Exami	ın/	1. Decedent's Name (First, Middle,La	A Amend			2. Date Month Augu	of Death	y Year	3. Time of Death 1409 hrs
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Funeral Director	- 1	5. Social Security Number 6. S	Sex 7. Age (In yrs. last	- "		ours Min. Ma	e of Birth(M		Birthplace (State or preign Country)
Any	- 1	Usual Residence of Decedent 10a. State 10b. County		wn or Location			1.10,	1111	10d. Inside City Limits
*	Director	Mayland Bat 10e. Street and Number	timore	10f.	Woodla Zip Code	WN	10g. (Citizen of What C	1 Yes 2 No
death with the Maryland or items 23a or 28a-f sho must be notified at once.		21 Walden 11. Martin Status	Codar Ct. 12. Was Decedent Ever in U.S.	13 Was Dec	2121	Origin? (Specify Yes	or No-	LI4 Race - As	merican Indian, Black,
	/ Funeral	1 Never Married 2 Marrie	Armed Forces? 1 Yes 2 No If Yes, Give Year	If Yes, sp		can, Puerto Rican, e		White, et $\mathcal{B}_{\text{Specify:}}$	
11215-0036 de filed within 72 hours after dental Hygiene, narked other than "natural", event, the Medical Examiner:	eted by	15. Decedent's Education (Specify Elementary/Secondary (0-12)	Only highest grade completed) College (1-4 or 5+)	Sa. Decedent's Us during most of	ual Occupation (G working life. DO N	1	e 16i	b. Kind of Busine	ess/Industry
21215-0036 uld be filed within 77 Mental Hygiene. marked other than	Completed	17. Father's Name (First, Middle, Las	ut)	и	nemplay 18.Mo	ther's Name (First, M	liddle, Maid	en Surname)	T
2 P P E 3	To Be	19a. Informant's Name/Relationship	1 11 1	19b. Mailing Addi		ber or Rural Rou	te Number	City or Town, S	State, Zip Code)
e, M I and 2 Health item 2		20a. Method of Disposition		ce of Disposition (edar C	20	Voeda c. Location - Cit	y or Town, State
트립트루		1 Burial 2 Cremation 3 4 Donation 5 Other Special 21. Signature of Funeral Service Lice	Mey Mey	matory or other plants of the	natory and Address of Fa	9 2 0	8 1	Catonsi	rille, Maryand
Balti Departi Importa		23a. Part I. Enter the disease, or con	tarter	3512	Frederi	ck Ave.	Balli tory arrest,	mrc, shock, or heart	dyna – A pproximate Interval
/Medical (*xaminer	Ì	failure. List only one cause on			,				Between Onset and Death
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cuted	_	events resulting in death) Last	Due to (or as a consequence of):						
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Division of Vital Records, P.O. Box 68760, within 24 hours after the law requires that the death certificate be executed thours after the function of the this certificate be executed to the two-ral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transcription and the control of the funeral director, page 2 should be detached for use as the burial - transcription and the control of the funeral director, page 2 should be detached for use as the burial - transcription and the funeral director, page 2 should be detached for use as the burial - transcription and the funeral director, page 2 should be detached for use as the burial - transcription and the funeral director, page 2 should be detached for use as the burial - transcription and the funeral director, page 2 should be detached for use as the burial - transcription and the funeral director, page 2 should be detached for use as the burial - transcription and the funeral director.	siciar	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of pregnal 1 Live birth 4 Pregnant at time of death 9 Unknown	2 Fetal de		topic pregnancy		23d. Date of del Month	Day Year
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Division of Vital Records, P.O. rate or Attending Physician: The law requires that the Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted.	Completed						a. Was an autopsy performe	prior deal	re autopsy findings available r to completion of cause of th? Yes 2 No
Vital Rec hysician: The this certificate I director, page	Be	25. Was case referred to medical examiner?	Hospital: 1 ✓ Inpatient 2 El	R/Outpatient 3	26.Place of De	eath (Check only one Nursing Home		sidence 6 0	Other:
on of Vi nding Physi th. : After this e funeral din	ion: To	1 ✓ Yes 2 No 27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury 2. FOUND: Day, Year) F	8b. Time of Injury	28c. Injury at V	Vork? 28d. De		injury occurred	Aller.
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the f	Certification:	2 Accident Investigat 3 Suicide 6 Could not determine	ation Jul 28, 2008 2 28e. Place of Injury - At hom	140 hrs e, farm, street, fac		g, etc. 28f. Loc		et and Number o	or Rural Route Number, City
Di To the Hospital within 24 hours a To the Funeral completely filled	Medical Co	29a. Certifier 1 Certifying Phys	ician: To the best of my knowledge, er: On the basis of examination and			d place, and due to t	he cause(s) and manner as	stated.
To To	Me	29b. Signature and title of certifier	and manner stated.		29c. License num	ber	29	d. Date signed	(Month, Day, Year)

State 31. Date filed (Month, Day, Year) Registrar DHMH 17 Rev 1/2001 OCME 2006

no

Ling Li, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

O.C.M.E.

August 26, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Sharon Marie Folkes State of Maryland / Department of Health and Mental Hygiene 2008 2797 1- For State Certificate of Death Reg. No egistrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3. Time of Death Month August 22, 2008 Medical Examiner HARON 1920 hrs 4a. Facility Name (if not institution, give street and number) 4b, City, Town, or Location of Death 4c. County of Death NIA 507 Gold Street Baltimore 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) Country) Months Days Hours Director 215-64-4182 52 M 2 X F Yrs 104 MARYLAND Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits NA Yes 2 No MARYLAND BALTIMORE death with the Maryland Director 10e. Street and Number 10g. Citizen of What Country? 507 STREE Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces White, etc. Never Married 2 No Yes Pages 1 and 2 should be filed within 72 hours after Specify: BLACK 4 X Divorced If Yes, Give Year Yes 2 No specify: 3 Widowed 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than " MD 21215-0036 IQTH GRADE OWN HOME HOME MAKER 17. Father's Name (First, Middle, Last 18.Mother's Name (First, Middle, Maiden Surname) Be of Health and Mental 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address. (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 is m (DAUGHTER) WILMOT CT., BALTIMORE, MD 21202 ETITIA KELLY 937 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, t: If i crematory or other place) 1 Burial 2 Cremation 3 08/29/2008 BALTIMORE, MARYLAND tant: or ot MT. CARMEL CEMETERY Donation 5 Other Specify: 22. Name and Address of Facility
JOSEPH H. BROWN JR. FUNERAL HOME 21. Signature of Funeral Service Licenses 2140 N. FULTON AVE, BALTIMORE, MD 21211 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Methadone intoxication Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and - transit The law requires that the death certificate be executed Physician/Medical 23a,2/,28a-f, perME, g883 9/12/08 TT X UNPENDED attending physician or use as the burial -AMENDED Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 V No 9 Unknown o. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Yes 2 V No 3 Probably 4 Unknown Completed Division of Vital Records, 24a Was an 24b. Were autopsy findings available autopsy ficate has b , page 2 sh prior to completion of cause of performed? certificate ✔ Yes 2 2 No Hospital or Attending Physician; 25. Was case referred to medical 26.Place of Death (Check only one) funeral director, Be Hospital: 1 Other₄ ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene this Inpatient 2 1 ✔ Yes After 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: n 24 hours after death.

The Funeral Director: A pletely filled in by the fu Natural Yes 2 X No Pending Fnd 8/22/08 Fnd 6:50 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 507 GOld St. Baltimore, MD 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 XCould not be Suicide found at home Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical within 2 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. August 23, 2008 _ ruc 30. Name and address of person who completed cause of death (item 23a) Assistant Medical Examiner Donna M. Vincenti, MD 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001 **OCMF 2006**

Registrar

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** August ,00 P M 28 2008 /Medical 4a. Facility Name (If not institution, give street and number 4c. County of Death Town, or Location of Death 4b. City, Examiner N/A Jul Move
If Under 1 Year If Under 24 Medical Center Maryand 5. Social Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6/28/1943 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1 **€** M/ 2 □ F 213-42-3516 65 Maryland Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland 10a. State 10h. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show "natural", or items 23a or 28a-f shov MD Timonium 1 ☐ Yes 2 X No Funeral Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 Tuder Court 21093 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Completed by 1 ☐ Yes 2√2 No Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, Inc. M. once. Loan Officer Mortage Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Minnie I. Barnhart Joseph H. Franz, Jr. 2 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phyllis Gerald / Friend Timonium, Maryland 21093 27 Tuder Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 9/3/2008 New Cathedral Cem. Baltimore, Maryland 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Towson, Maryland_21204 1050 York Road Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** Massive Subarach now /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within £4 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the humeral director, page 2 should be detached for use as the burlar-lransit resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Year Day 5 ☐ Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 ☐ Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one and manner stated. 29b. Signature an 29c. License number 29d. Date signed (Month, Day, Year) 22162

Registrar
DHMH 17 Rev 1/2001

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State

31. Date filed (Month,

ame and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Sig

JenW4

DeLawNTae Finley 08-06617 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 2008 27973 1- For State Certificate of Death Reg. No Registrar Physician/ 1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day August 29, 2008 1853 hrs Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Min. Months Hours Director 215 154887 1 X M Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits mo 1 / Yes 2 No 1timorE Pages 1 and 2 should be filed within 72 hours after death with the Maryfand nent of Health and Mental Hygiene. Director 10g. Citizen of What Country? 10e. Street and Number 23 USA 2 Funeral 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Ongin? (Specify Yes or No-Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married Yes If Yes. Give Year Yes 2 No specify: Widowed 4 Divorced ģ 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) marked other than MD 21215-0036 17. Father's Name (First, Middle, Last) Name (First, Middle, Maiden Surname Be 19a. Informant's Name/Relationship (Type, Print) MOTHER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) montpelier Important: If item 27 is njury or other traumatic ST BAHOME 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Baltimore, 9/6/2008 HANOUER 2 Cremation 3 Alden+ Cremation Donation 5 Other Specify: 21. Signature of Funeral Service Licensee BAITIMORE 23a. Part I. 📶 ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line /Medical Death a. Gunshot wound to chest Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Physician/Medical Examiner Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and attending physician a AMENDED UNPENDED Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Month Day Year past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. ģ Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed? death? certificate ✓ Yes 2 2 No 1 V Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other₄ Hospital: 1 Inpatient 2 V ER/Outpatient 3 Nursing Home 5 DOA Residence 6 After this 1 ✔ Yes Certification: To No 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Subject shot Aug 29, 2008 1813 hrs Natural Yes 2 V No Director: Pending 24 hours after death. 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide Could not be or Town, State) 3307 Bell Avenue , Baltimore , MD within 24 hours a To the Funeral determined (Specify) Found in garage 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

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Registrar DHMH 17 Rev 1/2001 OCME 2006

State

31. Date filed (Month, Day, Year) \$2. Registrar's Signature

Assistant Medical Examiner

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

OCME

111 Penn Street, Baltimore, MD 21201

O.C.M.E.

August 30, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygien 27974 For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1054 PM Hugust 27 GEORGE GLEBUS 2008 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore City Mency Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State or 28e-f show the Medical Examiner must be notified at 1 Yes 2 □ No Director 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after deeth with Depertment of Health and Mental Hygiene. Important: If item 27 is marked othar than "natural", or items 23a, any injury or other traumatic event, the Marical Examinatinal toward. 1.5. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📈 No Specify: White 3 Widowed 4 Divorced Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) GAUCER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Be IRENR 19a, Informant's Name/Relationship (Type 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wite 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify) 3 Pemoval from State 21. Signature of Funeral Service I 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sepsis Physician /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, the attending physicien Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 Other (specify) detached 1 ☐ Yes 2 ☐ No 9 Unknown sete has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed 2 No 1 Yes 2 No To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo Inpatient ٩ 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number cirsten Bacq, ND AM 2556996 259 August who completed cause of death (Item 23a) (Type, Print)

C New Medical Center D.O.M. 32. Registrar's 8 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician Green /Medical 4a. Facility Name Vf not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner N/A UVIVERS. tu of Maryland Med Social Security Number 8. Date of Birth (Month, Day) **FEB** 23 Birthplace (State or Foreign Country) Funeral Months Davs Hours Min 1960 578-92-0576 48 Director Maryland Usual Residence of Decedent 10a. State 10b Count 10c. City. Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Wedical Even that must be notified at 1 ☐ Yes 2 No Director Frederick MD Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 18 Mt. Olivet Boulevard USA Funeral 12. Was Decedent Ever in U.S. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces?

1
Yes 2
No Black, White, etc. 72 hours after 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes X No ð If Yes, Give Year or Dates: Specify Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Auto Mechanic Automotive is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Green Walton Marv Lou ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Lou Green - mother 18 Mt. Olivet Blvd., Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory, Inc. 9/2/2008 Baltimore, MD 21. Signature of Funeral Serv Steven H. Williams 22 Cremation Society of Maryland, Inc. 299 Frederick Road, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Alcoholic /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) and burial-tran law requires that the death certificate be exec Due to (or as a consequence of) Box 68760, physician Physician/Medical the attending | IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) P.0. the 9 Unknown signed by t I be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, ð 2 No 1 ☐ Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l autopsy The certificate Division of Vital 1 □ Yes 2 🗆 No 2 **N**No To the Hospital or Attending Physician: director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2₩No Medical Certification: To 1 patient 2 ER/Outpatient 3 DOA this After th funeral 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1- Alatural 5 Pending within 24 hours after death.

To the Funeral Director: A completely filled in by the ft 1 ☐ Yes 2 Accident investigation 2 □ No 6 Could not be 3 ☐ Suicide 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number

State Registrar

DHMH 17 Rev 1/2001

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completed cause of death (Item 23a) (Type, Print)

egistrar's Signatur

2008

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Baltimore

MD

Greene St

Amend #5, Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death August 29. 2008 Ye ar **Physician** 1:27 A M Goglia Susan Armstrong /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gilchrist Center for Hospice Care Towson If Under 24 Hrs. 5. Social Security Number 0 If Under 1 Year 8. Date of Birth (Month, Day, Ye Feb. 10, Birthplace (State or Foreign Country) . Age (In yrs. last birthday) **Funeral** Year) Months Days Hours Min 1 □ M 2**X**□ F Maryland 1949 Director 219-56-0030 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f show the Medical Examiner must be nutified at 1 □ Yes 2 No **Funeral Director** Baltimore Maryland Baltimore 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with U.S.A 21212 817 Kingston Road Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any Injury or other traumatic event, the Medical Examinat once. Black, White, etc. 1 ∐Yes 2 [ဤ If Yes, Give Year or Dates: 1 Never Married 2 Married 2 XNo Baltimore, Maryland 21215-0036 1 □Yes 2 No Specify Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Howard County Elementary/Secondary (0-12) College (1-4or 5+) 5+ Principal Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Esserwein В. Armstrong Albert ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland 21212 Michael C. Goglia, III Husband 817 Kingston Road 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Druid Ridge Cemetery 9-3-2008 Pikesville Maryland 21. Signa vice fun val Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final COLON CANCER METASTATIC **Physician** 2004 disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dian to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 → No 3 Ectopic pregnancy Month Day Year 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No 1 ☐Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) \(HOSPiCE \) 1 ☐ Yes 2 🙀 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 2 Accident 1 □ Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fi 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide the Hospital 29a. Certifier 🗯 certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signature and title of certific D64395 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6565 NEHARLES ST, SUITE 209 DANIEUE DEBERMAN, MO BALTIMOREINO 21204 32. Registrar's Signature 31. Date filed (Month, Day, Year) SEP 0 State 0 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryla	and / Department of Health and Mo	ental Hygiene
			For State Registrar	Certificate of Death	Reg. No. 008 27977
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death Month Day Year 3. Time of Death
V _k	/Medic	al	SPENCER 4a. Facility Name (If not institution, give street and number)	HOMER	08 27 2008 1250 AM
	Examir	er	TESSUP REGIONAL HOSPIT	TAL 4b. City, Town, or Location of Death	4c. County of Death ANNE ARUNDALE
	Funeral		5. Social Security Number 6. Sex 7. Age (In ye		8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)
	Director		213 02 89 6 1 MM 2 F 34	4 Yrs. Moritis Bays Hours Nill.	IOV. 28, 1973 MD
	fand ow			City, Town or Location	10d. Inside City Limits
	a-f sh	ctor	MD BA	ALTIMORE	1 X Yes 2 □ No
	or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a		1429 N. BROADWAY 11. Marital Status 12. Was Decedent Ever in	21213	USA offy Yes or No- 14. Race - American Indian,
(O	or Item	Funeral	Armed Forces? 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No	If Yes, specify Cuban, Mexican, Puerto F	
003	72 hours after death with the Maryland Instural; or Items 23a or 28a-f show dical Examiner must be notified at	d by	3 ☐ Widowed 4 ☑ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☒ No Specify:	Specify: BLACK
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nd	othe othe	Bec	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame)
yla	should be nd Menta i marked umatic ev		SPENCER HOMER, SR.	DIANA BROW	
Maryland	2 6 5 10		19a. Informant's Name/Relationship (Type, Print) DIANA BROWN	19b. Mailing Address (Street and Number or Rural 1429 N. BROADWAY, BAI	
re,	f Health f Health item 27 other tr		20a. Method of Disposition 20b		5500°0°0 DONNELL ST.
E E	Pages nent of ant: If it ary or o		1 Burial 2 □ Cremation 3 □ Removal from State Other (Specify)	1	/2008 BALTIMORE, MD 21224
Baltimore,	permit. Pages Department of Important: If I any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Facility WESI	EY CHAVIS, JR. FNRL. HM.
	40360		23a Part Enter the disease of complications that cause the de	2007–09 EASTERN AV	
	Pnysician ·		23a. Part . Enter the disease of complications that cause the de shock, or heart failure. Ast only one cause on each line. Immediate Cause (Final	ORESPIRATORY A	Interval Batween Onset and Death
	/Medical		disease or condition resulting in death) a. Due to (or as a cons		\\L_\(\)\
F	Examiner		Sequentially list conditions, b. FEV	ER	
N.	nsit n	nlner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	A T D S	
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x 68	The law requires that the death certifica tie has been signed by the attending ph bage 2 should be detached for use as th	/Med	IF FEMALE: 23c. If yes, outcome of preg		
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P.0.	that the deed by the detached	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown 9 ☐ Unknown		
S,	res the igned be de	by	Part II. Dther significant conditions contributing to death but not r	esulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
oro	v requir been s should	eted	ANEMIA	CALTA	1 Yes 2 WNo 3 Probably 4 Unknown
Records,	The law ate has page 2 s	Completed	THROMBOCYTOF	PENIA	24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
		a	25. Was case referred to medical	26. Place of Death	1 Yes 2 No 1 Yes 2 Yes
of V	ys dir	To B	examiner? 1 Tyres 2 No Hospital: 1 Tyrinpatient 2		ne 5 Residence 6 Other (Specify)
o uc	ding Ph h. After th funeral	lon:	27. Manner of Death 1 Matural 5 ☐ Pending (Month, Day Year)	28b. Time of 28c. Injury at 28c. Injury Work?	8d. Describe how injury occurred
Division	Attending r death. sctor: After by the fune	flcat	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At	M 1 ☐ Yes 2 ☐ No thome, farm, street, factory, office 2.	8f. Location (Street and Number or Rural Route Number,
Dİ	s after al Dire	Certification:	4 ☐ Homicide determined building, etc. (Spe	cify)	City or Town, State)
	To the Hospitel or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Examiner: On the basis of exami	nowledge, death occurred at the time, date and place, an ination and/or investigation, in my opinion, death occurre	nd due to the cause(s) and manner as stated.
	o the ithin 2 o the omplet	Med	29b. Signature and title of certifier	29c, License number	29d. Date signed (Month, Day, Year)
}	F ≯ F 8		Don Zulleta MI	D005358	6 08 27 2008
	1		30. Name and address of person who completed cause of death (II	tem 23a) (Type, Print)	NAM DRIVE Sto 350
			MOTTI MULLETA, 60	OLUMBIA MD 210	NAV DRIVE Ste 350
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registrar's Sig	anature (partie)	
			OLI VA		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No 2008 Certificate of Death 2. Date of Death Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1:20 p^M Philip Hoffman 29 2008 August Philip - Hoffman 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Baltimore Towson Gilchrist Center for Hospice Care 9. Birthplace (State or Foreign Country) **Ohio** 8. Date of Birth

Month Day

JAN 1 1920 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number Months Days Hours 1**™** M 2□ F 289-10-3492 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 1 ☐ Yes 2 No Towson Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21204 514 Piccidilly Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 X es 2 ☐ No 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 Widowed 4 ☐ Divorced WWII 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Electronics Electrical Engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ruth Davis Hoffman Harry 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 208 North Oak Street, Falls Church, VA Todd D. Hoffman - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory, Inc. 8/30/2008 Baltimore, MD 4 □ Donation 5 □ Other (Specify) ^{22, Name and Address of Facility}
Cremation Society of Maryland,
299 Frederick Road, Baltimore, 21. Signature of Funeral Service Licensee

Steven H. Williams 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy Month Day Year in the past 12 months? 5 ☐ Other (specify) 1 □Yes 2 □ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown scheme 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performe 2 🖸 No 1 ∐ Yes 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HO10. Ce 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation

Physician /Medical Examiner

permit. Pages 1
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Important: If ite
any Injury or ot
once.

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Funeral Director

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Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-5 shov ury or other traumatic event, If a Mexical Examinating it at the motified at

Baltimore, Maryland 21215-0036

the death certificate be executed ng physician and as the burial-trar 8129 108 certificate has been signed by the attending pricetor, page 2 should be detached for use as Hospital or Attending Physician; nours after death.

neral Director: After this confilled in by the funeral dire To the Hospital within 24 hours a To the Funeral C completely filled

Examine Physician/Medical Completed by Be Certification: To

25. Was case referred to medical 1 Yes 2 Ño 27. Manner of Death 1 Natural 2 ☐ Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated

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State Registrar

Medical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

SEP 02

29c. License number

29d. Date signed (Month, Day, Year) August 29, 2008

Killules St. Rolls Md 2,20x 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 1:45 A^M Doris S. Heald 2008 September /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Gilchrist Center Baltimore Towson | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day Year 1) | April 23, 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 3^{Year)}1920 **Funeral** 1 ☐ M 2 💢 F Maryland 88 216-12-7215 Director Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a, State 1 ☐ Yes 🎾 No Director Maryland Baltimore Parkville 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 8820 Walther Boulevard **USA** 21234 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White Be Completed by 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Exxon Comptometer Operator 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Louis Schurman Martha Fitzberger 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Janice Veloso, Daughter 9207 Hines Road Parkville, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Department of Important: If It any Injury or conce. 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Metro Crematory Inc. 09/02/08 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Libenced
Thomas Gregor Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final rears **Physician** un ge disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 menths? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause-given in Part I. <u>ک</u> a 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐Yes 2 ☐ No 1 ☐Yes 2 ☐No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760,

physician and the burial-transi attending pl certificate has been signed by the rector, page 2 should be detached this After 1

28a-f show

tem 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Profice Examinat must be not the Land

Pages 1 and 2 should be filed within 72 hours after death with

Hygiene.

and Mental

of Health a

Baltimore, Maryland 21215-0036

thin 24 hours after death.

the Funeral Director: A simpletely filled in by the fu within 2 To the I

State

Medical

29a. Certifier

(Check only one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License number

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bin

and manner stated.

iles of Pacto. MdZ(20) 6701 Al- Cha

Registrar's Signatu

Registrar

be executed and

Division or Vital Records, P.O. Box 68760 attending physician detached for been signed by should be detac

1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** 2008 2:45 pm August 28 DOROTHY MARGARET HOWARD-BEY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE MANOR CARE-ROLAND PARK If Under 1 Year | if Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 X F Director 217-38-5665 76 MAR 01 1932 MARYLAND Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 1√X es 2 No MARYLAND N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2016 DRUID HILL AVENUE 21217 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 📆 💢 o Specify Specify: ASIATIC ģ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed win Department of Health and Mental Hygien. Important: if tem 27 is marked other the any hijury or other traumatic event, the is 9th grade NURSING HEALTH CARE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be 2 JOSEPH CAMPBELL TERESA CAMPBELL 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilbert E. Howard Bey/Son 2016 DRuid Hill Ave., Baltimore, Maryland 21217 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) METRO CREMATORY 08/30/08 BALTIMORE, MARYLAND 21. Signature of Funera 22. Name and Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME P.A. Manue 1206 W NORTH AVENUE 23a. Part First the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shoot, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition DEMENTIA **Physician** ZHEIMER'S disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9□Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 2 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform al or Attending Physician: 1 s after death.

In Director: After this certifical or in by the funeral director, p 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide To the Hospital within 24 hours at To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 5059107 M.D 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BUSINESS 210 PRIVE REISTERSTOWN, CENTER ()MA 31. Date filed (Month, Day, Year) 32 Registrar's Signature State SEP 0 2 2008 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No.

DHMH 17 Rev 1/2001

Physician /Medical Examiner

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Be

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Examine

Physician/Medical

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Completed

Be

Medical Certification: To

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If the Machalle Examine must be notified as any injury or other traumatic event, If the Machalle Examine.

s 1 and 2 should be filed within of Health and Mental Hygiene. Item 27 is marked other than

Physician

/Medical

Examiner

certificate has been signed by the aftending physician and rirector, page 2 should be detached for use as the burial-transit

Hospital or Attending Physician: The law requires that the death certificate be executed

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

JAMES A HORAN

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

Reg. No. 20

3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 29 Huguit ZOUB 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) None Bultimer 1 Year | If Under 24 MNVEVS TV Number Manyland Medical Center 8. Date of Birth Month, Day, Year) MArch 22,1931 9. Birthplace (State or Foreign Days Pennsylvania Months Hours 207-26-5673 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County XXYes 2□No Baltimore Maryland None 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21210 5704 Roland Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian Black, White, etc. XX Never Married 2 ☐ Married 1 □ Yes XX No White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Religious Brother Charity

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

17. Father's Name (First, Middle, Last)

23a. Part 1. Enter the disease, or comp shock, or heart failure. List only

19a. Informant's Name/Relationship (Type. Print)

Brother Thomas S Kretz SJ

18. Mother's Name (First, Middle, Maiden Surname) Catherine Mullin

James A Horan

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5704 Roland Avenue Baltimore, Maruland 21210

20a. Method of Disposition 1 ☐ Burial 2 🛣 remation 3 ☐ Removal from State 4 Donation 5 ☐ Other (Specify) nature of Fun and Sorvice Lio Insee

20b. Place of Disposition (Name of cemetery, crematory or other place) GreenMount Crematory

20c. Location - City or Town, State Date 9/4/08 Baltimore, Maryland

22. Name and Address of Faffit tchell-Wiedereld runeral Home Inc 6500 York Road Baltimore, Maryland 21212 Approximate Interval Between Onset and Death prications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

IF FEMALE:

Sequentially list conditions, and all cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

tastatic Due to (or as a consequence of): Due to or as a consequence of)

Due to (or as a consequence of):

3 Ectopic pregnancy

23d. Date of delivery Month

23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 Unknown

5 ☐ Other (specify)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23e. Did tobacco use contribute to the cause of death? 2 X No 1 🗌 Yes

3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an autopsy

Dav

Year

25. Was case referred to medical examiner? 2 No 1 ☐ Yes

27. Manner of Death

1 Natural

2 Accident

3 Suicide

4 Homicide

5 ☐ Pending investigation

1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Time of

26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 ☐ Yes 2 X No

28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a, Certifie

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my opinion, death accurred at the time. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year)

29b. Signature and title of certifier J. Merkle MD

SEP 0 2 2008

6 ☐ Could not be

determined

P22133

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Thomas J. Merkle 31. Date filed (Month, Day, Year)

South Greene Street Bultimore 32. Registrar's Signature

10

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director,

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. 20 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death **Physician** Month Year ESLIE EACOCK 0238M 08 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1241 Dicus Mill Road Millersville Anne Arundel Social Security Number 7. Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, 6. Sex 1 2 M 2 ☐ F Birthplace (State or Foreign Country) **Funeral** Months Days Hours Director Oct 14, 1939 509-36-8410 68 Kansas Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or items 23a or 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Examinar must be notified at MD Anne Arundel Director Millersville 1 ☐ Yes 2√☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1241 Dicus Mill Road 21108 Funeral USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1)XiYes 2 □ No IfYes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. white ģ 3 X Widowed 4 ☐ Divorced 63-67 Be Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry unk 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4or 5+) 5 engineer 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Charlet Lee Heacock Sr Lola Blanche Hargrove ဥ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leslie Del Kaceynski/daughter 7903 West End Drive Baltimore, MD 21226 permit. Pages 1 and Department of Healt Important: If item 2: eny Injury or other i once. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Ronal d 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ANCREAS **Physician** 4 MUNITY /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 🔲 Ectopic pregnancy Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 **2** No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA filled in by the funeral 28b. Time of Injury 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 No 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only To the 29c. License number 29b. Signature and title of certifie 21438 30 Name and address of person who complete cause of death (Item 23a) (Type, Print) DEFENSE HIGHWAY (CHAR BM ستا 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2008

08-06371

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Nakhjavan Holamreza State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death Decedent's Name (First, Middle,Last) Physician/ Nakhjavan Gho1am Reza Month August 20, 2008 1248 hrs Medical Examiner Nakhjavan Holamreza 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Howard 7250 Edenbrook Drive T-2 Columbia 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Months Min Days Hours 380-84-9614 Director 52 Sept 5, 1955 Country ran 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location any 10a, State 10b. County 1 Yes 2 X No items 23a or 28a-f show Columbia Howard hours after death with the Maryland Director 10f. Zip Code 10g. Citizen of What Country 10e. Street and Number 21046 7250 Edenbrook Drive T2 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 Never Married 2 X No Yes white 4 X Divorced If Yes, Give Year Yes 2 X No specify Specify: \$ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) wilk Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than 'injury or other traumatic event, the Medical MD 21215-0036 Nuclear 4 engineer 18.Mother's Name (First, Middle, Maiden Surname) -unk 17. Father's Name (First, Middle, Last) Batool Kasmaee Reza Nakhjavan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 19a, Informant's Name/Relationship (Type, Print) Katrina Nakhjavan/daughter 415 N. Donahue Drive 11C Auburn, $_{
m AL}$ 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Beltsville, Md. 9-5-08 Chesapeake Crematory Donation 5 X Oth 23 Name and Andress of Facility Board 655 W. Baltimore Going Home Cremation Service P.O.Box Ballimore, MD 21201 Clarksville, Md. 21. Signatur of Roma priceducen Inter the disea e, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician /Medical Between Onset and Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last so the Hospital or Attending Physician; The law requires that the death certificate be executed ned by the attending physician and detached for use as the burial - tran x AMENDED 1 per me,14,16b,18,19b,20-22 per fh g883 9-10-08 vt Physician/Medical UNPENDED Box 68760, 23d. Date of delivery IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by Yes 2 No 3 Probably 4 ✔ Unknown Completed 24b. Were autopsy findings available peen 24a. Was an autopsy prior to completion of cause of certificate has death? performed? Yes 2 🗸 No Yes No 26.Place of Death (Check only one) 25. Was case referred to medical æ Other₄ Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 Inpatient 2 After this ۲ 1 V Yes 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day, Year 28b. Time of Injury Certification: 1 V Natural Yes 2 No Pending the Director; 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Suicide 6 Could not be or Town, State) within 24 hours a To the Funeral 1 determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier August 21, 2008 O.C.M.E ame and ad ress of person who completed cause of death (Item 23a) Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrar's Signature 31. Date filed (Month, Day, Year, State SED

Registrar

ORIGINAL

08-06552 Wayne Jefferson
Physicia Medical Examin
Funeral

06552		Please Typ	oe or Print in Black Ind	lelible I	nk. En	sure	All Co	pies	Are Le	gible.		
yne Jeffersor			ate of Maryland / Depar				Menta	al Hyg	giene			
		1- For State Registrar		ificate o	f Death					leg. No.	200	19 2798
Physicia dical Examin		Decedent's Name (First, Midd WAYNE	le,Last) JEFFERSON						Date of Dea Month August 2	Dav	Year	13-Time of Beath 2 0 1234 hrs
		4a. Facility Name (if not institution	on, give street and number)		4b. City, To		ocation of	Death		4c. Cou	inty of Deat	h
		Good Samaritan Hosp			Baltim							
Funeral		Social Security Number	6. Sex 7. Age (In yrs. las	t birthday)	If Under	_	If Under Hours	24Hrs.			Forei	
Director		212-82-3692	1 X M 2 F 46	Yr					03/28	/1962	Co	ountry) MD
ģ	H	Usual Residence of Decedent 10a. State 10b. County	10c. City, T	own or Loca	ation							10d. Inside City Limits
d 10 w a			7.47.0	THORE								1 X Yes 2 No
arylan 8a-f sl	cto	10e. Street and Number	<u> </u>	TIMORE	10f. Zip (Code				10g. Citizen o	of What Cou	untry?
the Minor 2	Director	3800 DELVERNE	POAD	21218					US	. Δ		
with 1	uneral	11. Marital Status	12. Was Decedent Ever in U.S.		as Deceder	nt of Hispa	anıc Origi		cify Yes or N	0- 14. 9	Race - Ame	rican Indian, Black,
death or iter must	ŭ,	Α	larried Armed Forces?		Yes, specify			Puerto R	ican, etc.)		White, etc.	
after	by F		vorced if Yes, Give Year 1979–82 or Dates:		Yes 2		-				cify: BLA	
hours 'natu	ted	15. Decedent's Education (Spe Elementary/Secondary (0-12)				Usual Occupation (Give kind of work done to working life. DO NOT use retired)						/Industry
36 nin 72 e. than '	ple	12	College (1-4 or 5+)	М	ECHAN	IC				LUA	OMOBI	LE
5-0036 Howithn 72 hours after death with the Maryland Hygiene. other than "natural", or items 23a or 28a-f show any the Medical Examiner must be notified at once.	Completed	17. Father's Name (First, Middle	, Last)				3.Mother's	Name (I	First, Middle,	Maiden Surr	name)	
21215-0036 uld be filed within 72 Mental Hygiene. marked other than " r event, the Medical.	Be (RALPH JEFFERS	ON				TI	HEO S	STEWAR	T		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	ဥ	19a. Informant's Name/Relations SHIRLEY ADKIN			ng Address OO DE					mber, City or		e, Zıp Code) 21218
imore, MD 2 Pages I and 2 shou nent of Health and N sant: If item 27 is n or other traumatic		20a. Method of Disposition		ace of Dispo					Date			r Town, State
Ore ges 1 a t of H : If it		1 X Burial 2 Cremation	n 3 Removal from State	ematory or o	other place)							
Baltimo permit. Page Department of Important: injury or ott		4 Donation 5 Other S 21. Signature of Funeral Service	F	WNSVI					-2008			LE, MD
1. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F. H												
Physician	\dashv	3a. Part I. Enter the disease, or	r complications that caused the death. It	Do not enter	/01-3 the mode o	f dying, s	uch as ca	rdiac or	respiratory a	rrest, shock,	or heart	Approximate Interval
/Medical	Ħ	failure. List only one cause Immediate Cause (Final disease	4 . 1 1				s di	seas	e of t	he Lui	ıg	Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a consequence of):		censi	.011						
		Sequentially list conditions,	b. Chronic drug t									
	ine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence of):						•			
W: =	Examine	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of):	of):								
xecuted and ransit	alE		dPI line a	a=b - 2	7, pe	rME.	988	8 2/	6/09 1			
be excessician		X UNPENDED	AMENDED T TITLE C		., pc	,,,	500					
Box 68760, death certificate be ex the attending physician defor use as the burial	sician/Medi	IF FEMALE: 23b. Was decedent pregnant in t	he 23c. If yes, outcome of pregna		etal death	3	Ectonic	pregnan	CV	23d. Da Mor	ate of delive	ery Day Year
x 68 h certi lendin use as	cia	past 12 months?	4 Pregnant at time of dear	th =	other (Spec	_	Lotopio	program	0,			24,
Boy te death the att	Physi	1 Yes 2 No 9 Un	known g Unknown									
ires that the signed by a detached	by P	Part II. Other significant condi	tions contributing to death but not res	sulting in the	underlying	cause giv	ven in Par	t I.				o the cause of death?
S, P												
w requires the should	plet									opsy	prior to	autopsy findings available completion of cause of
Reco	performed? death?											
The state of the s												
'hysic	10	1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 🗸 E			٠,,	Other4		Home 5	Residence		er:
28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28c. Injury at Work? 1 Yes 2 No 28d. Describe hor 28										e now injury o	ccurrea	
ivision or Attend after death, Director: I in by the f	cati		estigation	n a forma sta	and footom:			-	20f Location	(Stroot and I	Number or F	Rural Route Number, City
Divi	ij	dete	ald not be 28e. Place of Injury - At hore (Specify)	ne, iami, su	eer, ractory,	onice bu	many, etc		or Town,		Tamber of T	tara reade ramber, only
Division To the Hospital or Attend within 24 hours after death. To the Funeral Director: completely filled in by the i		29a. Certifier	Physician: To the best of my knowledge	e death occ	urred at the	time det	e and nle	ce, and c	tue to the ca	use(s) and m	anner as st	ated.
To the H within 24 To the F complete	Medical	one) 2 ✓ Medical Exa	aminer: On the basis of examination and	d/or investig	ation, in my	opinion,	death occ	curred at	the time, dat	e and place,	and due to	the cause(s)
2 2 2 2	Mec	29b. Signature and title of certifi	and manner stated.	***	29c	. License	number			29d. Date	signed (M	fonth, Day, Year)
Gracin.		Don m	Oil IM			O.C.N	1.E.			August	t 28, 200	8
		30. Name and address of person	n who completed cause of death (Item 2	23a)								
1		Donna M. Vincenti M	ID Assistant Medical Exami	iner 11	1 Penn	Street	Baltimo	re ME	21201			

State Registrar SEP 0 2 2008 DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

32. Registrar's Signature

08-06623								
Edwin Korbo	Cr.							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

n Kerbe, Sr		State of Maryland / Departme			nd Mer	ntal Hyg		2 l	008	2798	
Physicia ical Exami	an/	1. Decedent's Name (First, Middle, Last) Edwin Jerome Kerbe, Sr.					Date of Death Month August 29,	1		of Death 30 hrs	
1		4a. Facility Name (if not institution, give street and number) 2700 Port Covington Drive	4	b. City, Town, Baltimore		of Death		4c. County of	Death /A		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birt	hday) Yrs.	If Under 1 Y Months D	ear If Und		8. Date of Birth	, 1923	Foreign	State or aryland	
Maryland 28a-f show any d at once.	or	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town MD N/A Baltim		ore 15					1 X	side City Limits Yes 2 No	
death with the Maryland or items 23a or 28a-f sho must be notified at once.	Director	10e. Street and Number 920 Calwell Road		10f. Zip Code 21229) 		1	g. Citizen of Wha			
										an, Black,	
zithin 72 hou ene. er than "nat Medical Exa	mpletec	Elementary/Secondary (0-12) College (1-4 or 5+) 8 Custom Mechanical Contractor Construction									
ould be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	17. Father's Name (First, Middle, Last) Alfred Kerbe 19a. Informant's Name/Relationship (Type, Print) : 19l	h Mailine	Address (St	Flor	ence	Boston	faiden Surname) ber, City or Town	State 7in Co	ide)	
2 = 5 %	To	Dorothy Kerbe/Wife 9 20a. Method of Disposition 20b. Place of the pla	20 C		Raod	Balti		MD 21229			
permit. Pages I ar Department of Hea Important: If iter injury or other tr		1 Y Dullat 2 Clemation 3 Removalitori State	Park	c Cemete	,		3/08	Baltimo			
couted and transit transit	Examiner	or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Ursease or injury that imitated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):					TDAT				
be exesician	Physician/Medical	UNPENDED IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	₂ Fe	tal death her (Specify)	3 Ectop	oic pregnan	су	23d. Date of o	delivery Day	Year	
ires that the de signed by the d be detached f	<u>\$</u>	Part II. Other significant conditions contributing to death but not resulting	ig in the υ	inderlying caus	se given in I	Part I.		bacco use contrib	_		
The law requicate has been page 2 should	Completed						24a. Was a autop perfor	sy pr med? de		ndings available ion of cause of	
Attending Physician: rector: After this certifi by the funeral director,	To Be	27. Manner of Death 28a. Date of Injury 28b.	utpatient Time of I	3 DOA	Other ₄	Nursing	Home 5	Residence 6			
To the Hospital or A tendin within 24 hours after death. To the Funeral Director: A completely filled in by the fur	Certification:	The part of the pa									
To the Hosp within 24 ho To the Func completely f	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, de one) 2 Medical Examiner: On the basis of examination and/or and manner stated.		tion, in my opir	ion, death	occurred at		and place, and du	e to the cause		
)	Ē	29b. Signature and title of certifier Wordson The Youle			ense numbe	er		29d. Date signe August 30,		y, Year)	
6		30. Name and address of person who completed cause of death (Item 23a) Margarita Korell MD. Assistant Medical Examiner	111 P	enn Street	Baltimo	re, MD 2	1201				
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's Signature	,								

ORIGINAL

P.O. Box 68760. Division of Vital Records.

		Please	Type or Prin							•	
		For State	State of Ma	aryland	,	artment of F ertificate of		Mental Hy	_	0000	27000
		Registrar 1. Decedent's Name (First, Middle, L.	ast)			- Inicate or	Death	2. Date of D	Reg. No	2000	3. Time of Death
Physic /Medi		Stanlev R. K	owalski	Month Augus					Da t 24		6:45 P M
Exami		4a. Facility Name (If not institution, g				4b. City, Town, o	r Location of Deat			County of Dea	
<i>-</i>		Bradford Oaks Nur 5. Social Security Number 6.		e (In yrs. las	at hirthday	Clinton	_	8. Date of B		rince G	eorges thplace (State or Foreign
Funeral Director			XXM 2□F	89	Yrs.	Months Days	Hours Min.	August	ay, Year)	Co	mplace (State of Poleight Suntry) Marvland
ס		Usual Residence of Decedent						magabe			
farylar shov	5	10a. State 10b. County Maryland Prince	Georges	10c. City,		rlboro					10d. Inside City Limits 1 ☐ Yes 2 ☐ No
the N	Director	10e. Street and Number		oppe	SI PIC	10f. Zip Code			10g. Cit	tizen of What Co	puntry?
th with		9708 Shuttle	Court			20772	2		U	SA	
tems tems	Funeral	11. Marital Status	12. Was Decedent 8 Armed Forces?		13.	Was Decedent of H	ispanic Origin? (S an, Mexican, Puert	pecify Yes or N o Rican, etc.)	0-	14. Race - Ame	
oours afte	by F	1 ☐ Never Married 2 🔀 Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐Yes 2 ☐XN If Yes, Give Year or Dates:	lo		1 □Yes 2 No	Specify:			Specify:	White
2 hou	ted	15. Decedent's E	ducation	T	16a. Dec	edent's Usual Occup	pation	4	16b. K	ind of Business	
ithin 7	Completed	(Specify only highest g	rade completed) College (1-4or 5-	+)	life.	e kind of work done DO NOT use retired	during most of wor d)	king			
Hygien Hygien Ther th		17. Father's Name (First, Middle, Las	2		Fore	eman	18. Mother's Nam	ne /First Middle		rpenter	
ld be file lental Hi ked oth Ic event	To Be	Frank Kowalski	,				Sophie	Bielos		ourname,	
Idal yidalid Z FZ 13-0030 2 should be filed within 72 hours after death with the Maryland sand Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show raumatic event, the Medical Examires must be notified at	-	19a. Informant's Name/Relationship	(Type. Print)		19b. Mail	ing Address (Street	and Number or Ru	ıral Route Numi	ber, City o	or Town, State, .	Zip Code)
ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Health and Mental Hygiene. If item 27 is marked other than "natural", or flems 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at		Marie Teresa Kowa	lski- wife			Shuttle C					
permit. Pages 1 and 3 permit. Pages 1 and 3 Department of Health Important: If item 27 any Injury or other tr once.		20a. Method of Disposition 1				osition (Name of ematory or other place	,	Date		ocation - City or	
permit. Pages 1 Department of F Important: If ite any Injury or of		4 ☐ Dobation 5 ☐ Other (Spec 21. Signature of Funeral Service Lice		St.		ustine Ch. 22. Name and Addre		0/2008	Elk	ridge,	Maryland
Deparmine Deparmine any Ir				/,	1 .			neral H	ome	at MMP,	INC.
		23a. Part 1. Enter I. e disease, or cor shock, or h. art failure. List only	nplic tions that u d	the death.	Do not er	1250 Washa nter the mode of dyir	Ington 31 ng, such as cardiad	or respiratory	KY10 arrest,	ge, Mu	Approximate Interval Between
Physician		disease or con illion	. End	sto	age	Reno	1 Dis	lease			Onset and Death
/Medical Examiner		resulting in death)	Due to (or as a			_					
	<u>a</u>	Sequentially list conditions,	b. Due to (or as a	me	-	α					
Hansit ansit	Examiner	sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	2								
be executed sician and burial-transit		resulting in death) Last	Due to (or as a	consequer	nce of):						-
icate be	Physician/Medical		d								
eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of	of pregnanc	y					23d. Date of de	livery
death death deatte	icial	in the past 12 months?	1 ☐ Live birth : 4 ☐ Pregnant at			☐ Ectopic pregnanc ☐ Other <i>(specify)</i> _	У			Month	Day Year
at the ded by the stached	Phys	9 Unknown	9 🗆 Unknown					00 P: I			
The law requires that the death certificate ate has been signed by the attending physage 2 should be detached for use as the	è	Part II. Other significant conditions	contributing to death bu	it not resultii	ng in the i	underlying cause giv	en in Part I.		Yes 2		the cause of death?
w requir	etec							24a. Was			utopsy findings available
The lav	Completed							auto perf	psy ormęd?/	prior to death?	completion of cause of
	Be C	25. Was case referred to medical				· · · · · · · · · · · · · · · · · · ·	26. Place of Dea	1 □Yes ath (Check only	2 No one)	1 □Yes	3 2 No
dir ys	2	examiner?	Hospital: 1 ☐ Inpatie	nt 2□EF	R/Outpatie	ent 3 DOA Oth	er: 4 Nursing H	ome 5 ☐ Res	idence	6 □Other (Spe	ecify)
ng ng	io	27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	y (Year) 28	8b. Time o Injury	Worl	ryat k? Yes 2 ⊡No	28d. Describe	how inju	ry occurred	
l or Attending after death. Director: After	fical	2 Accident investigation 3 Suicide 6 Could not I	28e. Place of Inju	ry - At home	e, farm, st	reet, factory, office	162 2 1140				ural Route Number,
tal or rs afte al Dire	Certification:	4 ☐ Homicide determined	building, etc.	. (Specity)				City or To	wn, State	e)	
To the Hospital or Attenwith 24 hours after death To the Funeral Director: completely filled in by the	edical		hysician: To the best o miner: On the basis of and manner stat	examination	n and/or i	nvestigation, in my o	opinion, death occu	irred at the time	date an	d place, and due	e to the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	1			29c. Licens	e number	. [29d. Da	te signed (Mont	h, Day, Year)
		M. Ygala	uma4	MI	()	Do	05299	9	(08/3	3/2008
6		30. Name and address of person who	completed cause of de	eath (Item 2	3a) (Type	HO (12) +	al Drive	E G-1-	(LINTO	2072 T
Sta Regist		31. Date filed (Month, Day, Year) SEP 0 2 200	32. Registra	r's Signatur	los	29c. Licens DO(wi Dil			יעוועו	œ010°
negisi	en .	OL! 0 2 LO	1		3						

Box 68760. Division or Vital Records, P.O.

DHMH 17 Rev 1/2001

10

Medical

State

Registrar

29a. Certifier (Check only one)

29b. Signature and title

Dr. Machado

31. Date filed (Month, Day, Year)

o certitie

3110 Gracefield Rd. Silver Spring, MD

and manner stated.

LANGE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

D24035

29c. License number

29d. Date signed (Month, Day, Year)

8-27-09

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			for State Registrar	State o	f Marylan		artment of F ctificate of		Mental Hy	giene Reg. No. 20	08	27988	
	Physici	an	1. Decedent's Name (First, Midd	,,					2. Date of De Month	ath Day	Year	3. Time of Death	
	/Medic		Joan M. Kr						8	29	08	5:05 PM	_
	Examin	er	4a. Facility Name (If not institution University of r			Conta	Baltim	r Location of Deat	n	4c. County			
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year	If Under 24 Hrs.	8. Date of Bir	th	9. Birth	place (State or Foreign	-
	Director		420-48-7920	1□M 2 X F	69	Yrs.	Months Days	Hours Min.	9/26719	738"/	Geo	rgia	
	and w		Usual Residence of Decedent 10a. State 10b. Count	/	10c. Cit	ty, Town or Lo	cation					10d. Inside City Limits	_
	Mary Ind	tor	MD Frede	erick	Fre	ederic	2					1 X Yes 2□No	
	or 282	Director	10e. Street and Number				10f. Zip Code	•		10g. Citizen of	What Cou	ntry?	-
	s 23a	ral	2137 Unit BB, V				2170			USA			_
36	be filed within 72 hours after death with the Maryland and Hygiene. de Hygiene. de other than "natural", or items 23a or 28a-f show event, the Madical Examiner must be natified at	by Funeral	11. Marital Status 1 X Never Married 2 ☐ Ma	rried Armed Fo	2 □ No ve		Vas Decedent of H fYes, specify Cuba □Yes 2 X No	lispanic Origin? (S an, Mexican, Puerl Specify:	Specify Yes or No to Rican, etc.)	- 14. Rac Blac Specifi	ck, White,	can Indian, etc. White	
5-0036	2 hour	ted t		nt's Education	ates:	16a. Deced	lent's Usual Occup	ation		16b. Kind of B	usiness/In	ndustry	-
	- 3 (2)	Completed		est grade completed) College (1	1-4or 5+)	(Give	kind of work done of NOT use retired	during most of wor	rking				
2	filed within Hygiene. other than "	Con		6		Direc	ctor Chil			State		rment	_
Maryland 2121	should be filed within and Mental Hygiene. marked other than matic event, the Mental Hygiene.	Be	17. Father's Name (First, Middle George S. Knigh						ne (First, Middle, Willian		ne)		
Ž	s 1 and 2 should be to the stand Mental them 27 is marked oother traumatic eventher traumatic eventher traumatic eventher traumatic eventher traumatic eventher traumatic eventher traumatic eventher traumatic eventher tra	To	19a. Informant's Name/Relation			19b. Mailir	g Address (Street	_			, State, Zij	p Code)	
	alth a		Violet I. Rice	/ Friend		2137	7 Unit 28	, Wainwr	ight Ct.	, Frede	rick	MD 21702	
ore	jes 1 al t of Hea If item or othe		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	3 X Removal from	20b. F	Place of Dispo cemetery, cren	sition (Name of natory or other place		Date	20c. Location -	City or To	own, State	
Baltimore,	t. Pages rtment of rtant: If it		4 Donation 5 ☐ Other (Specify)	Fa		Cemetery	the state of the s		Valley,			
Bal	permit. Pages Department of Important: If i any injury or once.		21. hatur of Funeral Service	License	1	100	Name and Addre						
			23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Massive Lower GI Bleed Massive Lower GI Bleed										
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a			JI Blee	d				Onset and Death	
	Examiner		l and a second		(or as a conseq		1 1 1 2 2 4	oci do as				480	
		ner	Sequentially list conditions, if any, leading to immediate	b. Due to	or as a conseq	uence of):	d thromb	ocquiper	11 00				-
_	ecuted and transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Fail	ure of -	Transpl	anted Li	Ver					_
68760,	ificate be executed g physician and is the burial-transit	al E	resulting in death) Last				atic Arti						
		ledical		u				1					-
Ř	law requires that the death certifi as been signed by the attending 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?		tcome of pregna birth 2□ Feta		Ectopic pregnanc	y			ite of deliv	very Day Year	
0	he dez the a shed fo	ysic	1 ☐Yes 2 ☑No 9 ☐ Unknown	4 ☐ Pregi 9 ☐ Unkn	nant at time of o nown	death 5□	Other (specify) _			IVIC	JIIIII	Day Tour	
J.	w requires that the de been signed by the should be detached		Part II. Other significant condit	ions contributing to de	eath but not res	ulting in the ur	nderlying cause giv	en in Part I.	23e. Did to	obacco use con	tribute to t	the cause of death?	
g	quires an sign uld be	ed by							1 🗆 '	∕es 2 💢 No	3□ Pro	bably 4 ☐ Unknown	
ပ္ပ	e faw re has be e 2 sho	plet							24a. Was		Were auto	opsy findings available ompletion of cause of	
Vital Records,	ag ate	Completed							perfo	rmed?	death? 1 □ Ye s		
Z = 1	slcian: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			Oth	or:	ath <i>(Check only o</i>	,			_
5	g Phy er this eral di	n: 1	1 Yes 2 No 27. Manner of Death	28a. Date	Inpatient 2 of Injury	28b. Time of	L 3 L DOA	4 LI Nursing F	fome 5 ☐ Resident Re	dence 6 □Oth now injury occur		ify)	-
<u> </u>	arth. arth. ar: Aftu	atio	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (<i>Mon</i> Igation	th, Day, Year)	Injury		k? Yes 2 □No					
DIVISION	l or Atte after de Directo d in by tf	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deteri	nined 28e, Place	of Injury - At hoing, etc. (Specit	ome, farm, stre	eet, factory, office		28f. Location (: City or To	Street and Numb vn, State)	ber or Rur	al Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director; to	Medical C	29a. Certifier (Check only one) Certify 2 Medica	ng Physician: To the I Examiner: On the b	e best of my kno asis of examina ner stated.	owledge, death ation and/or in	n occurred at the til restigation, in my c	me, date and plac opinion, death occi	e, and due to the urred at the time,	cause(s) and m date and place,	anner as	stated. to the cause(s)	
	Го the within Го the хощр(к	Mec	29b. Signature and title of certific		,,o, stated,		29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year)	
	/		Maria	100			11	8483	7665	8/29	108		
	16		30. Name and address of person				Print)						-
			31. Date filed (Month, Day, Year		22 tegestrar's Signa		ne St	baltimon	e ,MD	21201			_
	Sta Registr			2 2008	Alexa	H	houll .						

DHMH 17 Rev 1/2001

Levon McCray 08-06627 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 2008 **UNK UNK** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3. Time of Death Physician/ Month August 30, 2008 0145 hrs Medical Examiner LEVON EUGENE McCRAY 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) 903 Valley Street **Baltimore** If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Foreign Months Hours Days Director Country) MD 1 X M 2 F Yrs 217-15-2851 11 21 Usual Residence of Decedent 10d. Inside City Limits any 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No with the Maryland notified at once. BALTIMORE MD Director 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 2316 E. PRESTON Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. death 1 X Never Married 2 2 X No Yes If Yes, Give Year Specify: BLACK Widowed Yes 2 X No specify: 4 Divorced 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) other than "r Elementary/Secondary (0-12) College (1-4 or 5+) 72 Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 77. Department of Health and Mental Hygiene. Important: If item 27 is marked other than CLOTHING 12TH SALES 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) traumatic event, Be EUGENE OLIVER CASSANDRA EVANS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PRESTON ST., CASSANDRA EVANS/MOTHER 2316 E. BALTIMORE, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State 5712 O'DONNELL ST. crematory or other place)
Trinity Cemetery 1 X Burial 2 Cremation 3 Removal from State 09/13/2008 BALTIMORE, MD 21224 Donation 5 Other Specify: 0 22. Name and Address of Facility WESLEY CHAVIS, JR. FNRL. HM. 21. Signature of Funeral Sovice Licenses BALTIMORE. 2007-09 EASTERN AVE. e, or complications that crused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Part I. Enter the disease, or complication failure. List only one cause on each line Approximate Interval **Physician** en Onset and /Medical Death a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last The law requires that the death certificate be executed and transit Physician/Medical 20b per fh g884 10-9-08 vt the attending physician ared for use as the burial -X AMENDED UNPENDED Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Year Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknowr 23e. Did tobacco use contribute to the cause of death? icate has been signed by page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy this certificate has death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: Other₄ Residence 6 V Other: Scene DOA Nursing Home 5 Inpatient 2 ER/Outpatient 1 V Yes No 28a. Date of Injury After t 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Injury Certification: Subject shot Aug 30, 2008 1 0130 hrs Natural Yes 2 🗸 No Pending Director: d in by the f 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) 903 Valley Street, Baltimore, MD (Specify) Street 4 V Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ca To the 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within and manner stated Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State

DHMH 17 Rev 1/2001 OCMF 2006

Registra

Assistant Medical Examiner

32. Registrars Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

August 30, 2008

30. Name and address of person who completed cause of death (Item 23a)

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day 2008)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

1 - Registrar amend #1&9 per Phy &FH G883 9694608 Death

Reg. No. Reg. No. 2 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Tericia Moss **Physician** 2005 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Som MORE ARITAN MAL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1□M 2**⊠**F 214-90-6445 08/07/1962 Maryland Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, it a Medical Examination to nother day once. 1 XYes 2 No Director Maryland 10e. Street and Number altimore 10g. Citizen of What Country? 14. Race - American Indian, 3101 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 🛣 If Yes, Give Year or Dates: 2 No 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working Jife. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) UNK 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Baltimore, Maryland Mildred Moss 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State on Cemetery 109/06/2008 Lansdowne Maryland 22. Name and Address of Facility The Derrick C. Jones Funeral Home, P. A. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 4611 Park Heights Ave. Baltimore, Maryland 23a. Part 1. Enter the disease, or complication at caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner CINETO BACTER Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner ALOUIRED ending physician and use as the burial-tran O. Box 68760, After this certificate has been signed by the attending funeral director, page 2 should be detached for use as IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Medical Certification: To Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2. No 2.0 No 1 □Yes 1∏Yes 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \(\text{(Specify)} \) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident within 24 hours after death

To the Funeral Director:
completely filled in by the i 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 🗠 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the 29d. Date signed (Month, Day, Year) 29c. License number To 1 29b. Signature and title of certifier RES-000

State

Registrar

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BALTINORE

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

31. Date filed (Month, Day, Year)

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Registrar's Signalare

Hugh MITCHELL 08-04950 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend #9 State of Maryland / Department of Health and Mental Hygiene

amend Item / per fh, g894,0811/09dhb

Red. No.

Red. No. **UNK UNK** 1- For State Registrar Reg. No 1. Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day June 26, 2008 2230 hrs Medical Examiner Hugh Mitchell 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death "210 S. Gilmore Street 210 S. Gilmor St. **Baltimore City** 7. Age (In yrs. last birthday)nk If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 5. Social Security Numberunk 6. Sex unk Months Days Hours Foreign Director July 09,1934 1 XM 2 F 73 Country) Yrs Usual Residence of Decedent 10a. State any 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 No MD Baltimore hours after death with the Maryland Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 210 S. Gilmore Street 21223 USA Funeral 12. Was Decedent Ever in U.S 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No 14. Race - American Indian, Black, Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. unk 1 Never Married 2 Married Yes 3 Widowed If Yes, Give Year 4 Divorced Yes 2 X No specify: Specify: white ş 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done un $\sqrt{16b}$. Kind of Business/Industry unk Completed during most of working life. DO NOT use retired) Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 ho Department of Health and Mental Bygiene. Important: If item 27 is marked other than "na Injury or other transmatic event, the Medical Exp. Elementary/Secondary (0-12) College (1-4 or 5+) 72.1 unk unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unk unk Be ို 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) O.C.M.E. 111 Penn Street Baltimore, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 crematory or other place) Removal from State Donation 5 X Other Specify: in state 21. It ure of Funeral ice Licensee and a Solution e State Anatomy Board 655 W. Baltimore Street Mrector IRaltimore, MD 21201
orl. Enter the yease in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart and Approximate Interval Physician we. List only one cause on each line. Between Onset and /Medical Death Immediate Cause (Final disease or condition resulting in death) a. Probable atherosclerotic cardiovascular disease xaminer Due to (or as a consequence of) Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last by the attending physician and ached for use as the burial - transit Physician/Medical X AMENDED 23a,27, perME, g883 9/4/08 TT 4a per ME g892 6/16/09 TT X UNPENDED The law requires that the death certificate be Box 68760, IE EEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Yes 2 ✔ No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of certificate has performed? death? 2 No ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical the Hospital or Attending Physician: 26.Place of Death (Check only one) Be examiner? Hospital: 1 Other: DOA Nursing Home 5 Residence 6 ✔ Other: Scene ER/Outpatient 3 this Inpatient 2 1 🗸 Yes ဥ No After 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: within 24 hours arter ucan...

To the Funeral Director: A 1 X Natural Yes 2 No Pending 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 _ Suicide Could not be determined 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar Upme

SEP

Margarita Korell MD.

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a)

2008

nell

Assistant Medical Examiner

32. Registrar's Signature

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

June 28, 2008

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 0 0 8 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Augu **Physician** 200 8 William Lawrence Mockabee /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ba +11110 MG Se If Under 8. Date of Birth (Month, Day, Year)
July 20,1950 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday If Under 1 Year Social Security Number **Funeral** Months Days Hours 1 🛛 M 2 🗆 F 58 MD 218-56-2204 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a State 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1√∑Yes 2 ☐ No Director Baltimore MD 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 1703 Holabird Road 21222 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ▼ No If Yes, Give 1 Never Married 2 Married $\mathcal{W}(I/I/\mathcal{Q}/\mathcal{W}) = III/\mathcal{O}\mathcal{CK}\mathcal{Q}_{\mathcal{A}}$ altimore, Maryland 21215-0036 1 □Yes 2 🛛 No 2 Specify: White 3 Widowed 4 NDivorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than "any injury or other traumatic event, the Mean injury or other traumatic event, the Mean injury or other traumatic event, the Mean injury or other traumatic event, the Mean injury or other traumatic event, the Mean injury or other traumatic event. Elementary/Secondary (0-12) College (1-4or 5+) Hoover Vacuum <u>Salesman</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be ပ William F. Mockabee Joyce Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type. Print) 13 Glyer Court, Reisterstown, MD 21136 <u>Diane P. Mincher</u> Sister 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation 8/29/08 Hampstead, MD 22. Name and Address of Facility Signature of Funeral Service Licenses 11824 Reisterstown Road cambs Eline Funeral Home Reisterstown, MD 21136 Tree Approximate Interval Between Onset and Death Rart 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or an a con requence of): Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of) Examiner The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) attending physician for use as the buria by Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 2 🗆 No detached 9 Unknown cate has been signed by page 2 should be detact Part I. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1√Ž Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death? certificate 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 📈 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2/1 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes Certification: To After this 28a, Date of Injury 28d. Describe how injury occurred 28b. Time of 27. Manner of Death 28c. Injury at Work? (Month, Day, Year) 5 Pending investigation 1 Natural 1 ☐Yes 2 ☐No 2 Accident

Division of Vital Records, P.O. Box 68760,

Hospital or Attending Physician: n 24 hours after death.

e Funeral Director: Af letely filled in by the fur

State

Medical

29b. Signature and title of certifier

29c. License number

1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 28/2006

28f. Location (Street and Number or Rural Route Number, City or Town, State)

npleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co 000

uare Drive Baltimore

Date filed (Month, Day, Year)

3 Suicide

29a. Certifier

4 Homicide

6 □ Could not be

determined

32. Registrar's Signature

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

ORIGINAL

Registrar

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			For State of N 1 - State Registrar	laryland / Dep <i>Ce</i>	ertificate of			giene Reg. No.2	108	27993	
			1. Decedent's Name (First, Middle, Last)				2. Date of De	ath Day	Year	3. Time of Death	
	Physicia /Medic		Paul B. Miller				August		008	10:10A ^M	
	Examin	_	4a. Facility Name (If not institution, give street and numbe	7)		r Location of Death		4c. County of Death			
			Oak Crest Care Center 5. Social Security Number 6. Sex 7. A	ige (In yrs. last birthda)	Parkvil.		8 Date of Bird	Baltimore th 9. Birthplace (State or Foreign			
	Funeral Director		220-07-2150 1 M 2 X F	95 Yrs.	Months Days	Hours Min.	8. Date of Bird (Month, Da 1/23/1	ÿ, Year) 913	Cou	rland	
	and and t	}	Usual Residence of Decedent 10a. State 10b. County	10c. City, Town or I	Location					10d. Inside City Limits	
	Mary -f sho ied a	ğ	MD Baltimore	Parkvill	e					1 ☐ Yes 2 No	
	r 28a	Director	10e. Street and Number		10f. Zip Code			10g. Citizen o	f What Cou	ntry?	
	th with 23a o 1st be		8800 Walther Blvd apt # 2	2308	21234			USA			
	ems ems	Funeral	11. Marital Status 12. Was Deceder Armed Forces	t Ever in U.S. 13	B. Was Decedent of H If Yes, specify Cub	lispanic Origin? (Span, Mexican, Puert	pecify Yes or No o Rican, etc.)	- 14. Ra	ace - Ameri ack, White,		
36	s afte	by Fu	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates	No No	1 ☐ Yes 2 ☐ No	Specify:		Spec	ify:		
5-0036	should be filed within 72 hours after death with the Maryland nd Mental Hyglene. r.marked other than "hatural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at	q pa	3 ☐ Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education	16a. Dec	edent's Usual Occur	dent's Usual Occupation			White 16b. Kind of Business/Industry		
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212	d with giene gr tha	Completed	Elementary/Secondary (0-12) College (1-40	Home	maker			Own Ho	ome		
Maryland 2121	sal Hy d othe	Be	17. Father's Name (First, Middle, Last)			18. Mother's Nan	ne (First, Middle,	Maiden Surna	ame)		
yla	ould the marked larked	P	Frederick E. Bauer			Margaret					
Mar	f2sh hand 7 is m traum		19a. Informant's Name/Relationship (Type. Print)		iling Address (Street			· ·			
e,	1 and Healt em 2		Wilbur Oscar Miller / Hus 20a. Method of Disposition		Walther position (Name of rematory or other pla		mate Date	20c. Location		1D 21 234 own, State	
ğ	ages ent of t: If it y or o		1☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stat 4 ☐ Donation 5 ☐ Other (Specify)	e	rematory or other pla on Nat'l C	1	2000	Arling	ton 1	/irginia	
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Dipartment of Healin and Mental Hygiene. Important: If inem 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Funeral Service Licensee					-9.			
B	Dup		Meller a St	F	22. Name and Addre	n Funeral	. Home,	Inc. 10	ว์รือ Y	ork Road	
			23a. Part1. Enter the disease, or complications that curshock, or heart failure. List only one cause on each	ed the death. Do not e line.	enter the mode of dyli	ng, such as cardiad	or respiratory a	rrest,		Approximate Interval Between	
Ġ.	Physician		Immediate Cause (Final disease or condition		ers Den					Onset and Death	
1.	/Medical		resulting in death)	as a consequence of):							
N	Examiner	_	Sequentially list conditions, b.	Debility							
	led Isit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	as a consequence of):							
δ,	execut and al-trar	Examiner	that initiated events resulting in death) Last C	is a consequence of):							
68760,	The law requires that the death certificate be executed the has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	edical									
	tificat ig phy as th	ledi									
Box	th cer tendir r use	Physician/M	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth		3 □Ectopic pregnanc	y			Date of deliv		
E	e dea he at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		5 ☐ Other (specify) _	*			Month	Day Year	
о. О	hat th d by t detach		Part II. Other significant conditions contributing to death	but not resulting in the	underlying cause giv	ven in Part I	23e. Did 1	obacco use co	ontribute to	the cause of death?	
Vital Records,	signe d be c	l by	Tartin Cindi diginican continue continu	Dat not roouting in the	andonying cauce gr		1 🗆	N.		bably 4 □Unknown	
Ö	w require been sig should b	Completed		·			24a. Was	an 241	h Wara sut	opsy findings available	
æ	he lav e has ige 2	mp					auto perfe	psy ormed?	prior to co death?	ompletion of cause of	
ta	an: T tificate or, pa		25. Was case referred to medical			26. Place of Dea	1 Yes	2 No	1 □ Yes	2 No	
<u> </u>	ysicia is cer direct	o Be	examiner? 1 ☐ Yes 2 🔭 No Hospital: 1 ☐ Inpa	itient 2 ☐ ER/Outpati	ient 3 DOA Oth	nor:	lome 5 ☐ Resi		Other (Spec	ify)	
Division or	ding Physician: The	T :U	27. Manner of Death 1 Matural 5 Pending 28a. Date of It	njury 28b. Time Day Year) Injury			28d. Describe				
Sio	endir eath. or; Al	atic	2 Accident investigation		M 1	Yes 2 □ No					
Ĕ	or Att fler de direct n by t	Certification:	determined 200. Flace 01	njury - At home, farm, : etc. <i>(Spe</i> c <i>ify)</i>	street, factory, office		28f. Location (City or To		mber or Ru	ral Route Number,	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.		29a. Certifier 1 L Certifying Physician: To the be	st of my knowledge de	eath occurred at the t	ime, date and place	and due to the	cause(s) and	manner se	stated	
	e Hos 24 hc Fun etely i	Medical	(Check only one) Certifying Physician: 10 the best of the basis and manner and manner	of examination and/or							
	To the within Fo the xomple	Me			29c. Licens	se number		29d. Date sig	ned (Month	, Day, Year)	
			I will I fla		HO	005z36S		AUG	w+3	1,2008	
	0,		30. Name and address of person who completed cause of	f death (Item 23a) (Typ	e, Print)	1 0	1. 11	10 1	1 21	7741	
	12	D j	Remail Jettieys, DU	8800 Wal	than /Soule	Vard i Ke	activille,	Marylan	Jail		
	Sta Registi		31. Date filed (Month, Day, Year) SEP 0 2 2008 32. Regi	f death (Item 23a) (Typ \$800 W.a.) strar's Signature	book						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day AUGUST ROBERTA KAY NEWNAN 2008 3:40 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 1901 Conowingo Road Bel Air Harford If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Davs | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) Birthplace (State or Foreign Country) Hours 1 □ M 2 🗙 F 60 May 24, 1948 Ohio 215-54-0197 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐Yes 2 XNo Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1901 Conowingo Road 21014 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☑ Married 1 ☐ Yes 2 🖾 No 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Assistant Principal Public Schools 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert S. Blackburn Kathleen Kay Knisley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Timothy P. Newnan Sr. / Spouse 1901 Conowingo Road, Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 9-1-08 Mary Epis. Ch. Cem. Abingdon, Maryland 21. Sign ture Fune Service Lice 23. Name and Address of Facility McComas Funeral Home, P.A. 50 W. Broadway, Bel Air, MD 21014 23a. Part 1. Enter the disease, or complication that an ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one can see o and him. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Mondo

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

Funeral

Director

28a-f show

Director

Completed by Funeral

Be

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner in ust be inclined at once.

Baltimore, Maryland 21215-0036

law requires that the death certificate be executed

To the Hospital or Attending Physician;

Division of Vital Records, P.O. Box 68760;

Examiner sician and burial-transit attending physician for use as the buria Physician/Medical cate has been signed by the page 2 should be detached Completed by certificate Be After this funeral dire Certification: To within 24 hours arren cocons To the Funeral Director: Aff

Sequentially list conditions, if any, leading to Immediate cause. Enter Underlying Julies (Lisease or word) that initiated events resulting in death) Last	b. Due to (or as a consect C. Due to (or as a consect Due to (or as a consect d.	quence of):	er		7	yews	
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregn 1 ☐ Live birth 2 ☐ Fetr 4 ☐ Pregnant at time of 9 ☐ Unknown	al death 3 ☐ Ectopio	c pregnancy (specify)		23d. Date of delivery Month Day	Year	
Part II. Other significant conditions	contributing to death but not res	ulting in the underlying	cause given in Part I.		24b. Were autopsy find prior to complete death?	4 Unknown	
25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)			
1 Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3 🗆 I	DOA Other: 4 ☐ Nursing	Home 5 ☐ Residence	6 ☐ Other (Specify)		
27. Man r of Death 1 Natural 5 Pending 2 Accident investigati	28a. Date of Injury (Month, Day, Year) on	28b. Time of Injury M	28c. Injury at Work? 1 □ Yes 2 □ No	28d. Describe how in	jury occurred		
3 Suicide 6 Could not determine		ome, farm, street, factory)	28f. Location (Street City or Town, Sta	28f. Location (Street and Number or Rural Route Number, City or Town, State)			
29a. Certifier 1 Certifying I 2 Medical Ex	Physician: To the best of my know aminer: On the basis of examination and manner stated.	owledge, death occurre ation and/or investigation	ed at the time, date and pla on, in my opinion, death oc	ce, and due to the cause curred at the time, date a	e(s) and manner as stated and place, and due to the o	ause(s)	
29b. Signature and title of certifier	000,00	()-1 2	9c. License nymber		Date signed (Month, Day,	Year)	

State Registrar

Medical

31. Date filed (Month, Day, Year)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MADHU CITAL DITEY MD 656



N, c かっ 15, Berナ ん の い Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

			Pleas	e Type or Prir							ble.	
	-	For State Registrar		State of Ma	aryland	-	artment of F rtificate of			iene _{eg. No.} 2 ()	08	27995
Physicia /Medic		1. Decedent's Nam	ne (First, Middle, i Leon N	,					2. Date of Dear	+ 27, 2	Year 2008	
Examin				nmunity Hos	nital		4b. City, Town, o Lanh	r Location of Death		4c. County		orge's
Funeral		5. Social Security N			e (In yrs. la		If Under 1 Year Months Days		8. Date of Birth	9. Birthplace (State or Foreign		
Director		577-20-0 Usual Residence of		- X	87	Yrs.			Aug 1,	1921 1	Penns	sylvania
show	<u>-</u>	10a. State MD	10b. County Prince	George's		Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 ☐ No
h the N or 28a-f	Funeral Director	10e. Street and Nu			1170		10f. Zip Code		1	0g. Citizen of	What Co	untry?
ath wit s 23a c nust be	al D	3504 01i	iver Str		Francia II O	10		0782	masife. Van av No	USA 14. Race - American Indian,		
ırs a	þ	11. Marital Status1 □Never Marr3 □ Widowed	ried 2 🛣 Married	12. Was Decedent Armed Forces? 1	No		Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2X No	an, Mexican, Puert Specify:	o Rican, etc.)	Bla	ck, White	e, etc.
"natura	Completed	(Spec	15. Decedent's cify only highest	Education grade completed)		(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	unk unk	16b. Kind of B	usiness/l	ndustry
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should nd Mer marke imatic	ပို	Gus Joh 19a. Informant's N	n Nichol Iame/Relationship			19b. Maili	ng Address (Street		Anne Pt ural Route Numbe	·	, State, Z	(ip Code)
and 2: ealth a n 27 is ner trau				1s/spouse			0liver	Street Hy	,		207	
ages 1 ant of H t; If iten y or oth			•	Removal from State	20b. Pla	ace of Dispo emetery, cre	osition (Name of matory or other place	ce)	Date	20c. Location	- City or	Town, State
permit. F Departme Importan any injur		21. Sign ton of E		211	ector	- 4	2. Name and Addre	-		Baltim	ore	Street
		23a. Part1. Enter shock, or hea	the disease, or co art failure. List or	omplications that cause only one cause on each li	d the death.	. Do not en	altimore, ter the mode of dyi	ng, such as cardia	or respiratory ari	est,		Approximate Interval Between Onset and Death
Physician /Medical		Immediate Cause disease or condition resulting in death)	on	a. myoc Due to (or as			arction					5 days
Examiner		Sequentially list co	onditions	b. cong	estiv	e hea	rt failur	е				5 days
ted nsit	Examiner	Sequentially list contains to it cause. Enter Undo Cause (Disease or	lerlying r injury	Due to (or as	а попесци	ence off):						
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ficate by physic is the b	edica			d						-		
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was deceder in the past 12 1 ☐ Yes 2 9 ☐ Unknown	2 months? □ No	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal	death 3[⊒Ectopic pregnanc ⊒ Other <i>(specify)</i> _	у			ate of del onth	ivery Day Year
e law requires that the de has been signed by the	þ	Part II. Other sign	ificant condition	s contributing to death t	out not resul	Iting in the u	underlying cause giv	ven in Part 1.		_		the cause of death?
law req as beer 2 shou	Completed								24a. Was a	sv	prior to	utopsy findings available
n: The ficate h r, page									perför 1∐ Yes	med? 2 No	death? 1 ☐ Yes	2040
iysiciai iis certii directo	To Be	25. Was case refe examiner? 1 Yes 2		Hospital: 1 Dippati	ent 2□E	ER/Outpatie	nt 3 DOA Oth	26. Place of Deaner: 4 ☐ Nursing F	ath <i>(Check only or</i> Home 5 ☐ Resid		her (Spe	cify)
ding Pt		27. Manner of Dea 1 ☑ Natural	ath 5 □ Pending investiga	28a. Date of Inj (Month, Da		28b. Time o Injury	of 28c. Inju Wo	ryat rk?]Yes 2 ∐ No	28d. Describe h			
To the Hospital or Attending Physician: The Within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Certification:	2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could no	t be 28e. Place of in	l jury - At hor tc. <i>(Sp</i> ec <i>ify</i>	me, farm, st	reet, factory, office		28f. Location (S City or Tow		ber or Au	ural Route Number,
ne Hospit a n 24 hours ne Funera bletely fille	dical	29a. Certifier (Check only one)	2 ☐ Medical E	Physician: To the best xaminer: On the basis of and manner s	of examinati tated.	ion and/or i	nvestigation, in my	opinion, death occ	urred at the time,	date and place	, and due	e to the cause(s)
To the within To the complex c	ğ	29b. Signature and	d title of certifier				29c. Licens	se number	7	29d. Date sign	ed (Mont	h, Day, Year)
		30. Name and add	dress of berson w	ho completed cause of	death (Item	23a) (Type	, Print)	17471	6	010	110	0
		Wasee	em Hus	ssain, mo.	750	001-10	nover to	arkivay,	Suite 10	Gree,	nbel	t, MD. 20770
Sta Registr	te ar	31. Date filed (Mo.	SEP 0 2	2008 32 segist	iai s signat	F A	me					h, Day, Year) 8 +, MD. 20770

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Year **Physician** 20:45 PM Frances Μ. Ness 8 2008 27 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Hangland Medical Center Bathmore 8. Date of Birth (Month, Day, Year) 4. 1942 5. Social Security Number If Under 1 Year | If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) 6 Sex **Funeral** 1 ☐ M 2 🔀 F 66 198-32-9523 Pennsylvania Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at Pa. 1 ☐Yes 2 ☐No York York Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1844 North George Street 17404 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify: White ģ 3X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within Department of Health and Mential Hygiene. Important: If item 27 Is marked other than "any Injury or other traumatic event, the Meg Elementary/Secondary (0-12) College (1-4or 5+) Laborer Manufacturing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Anna Charles Dedrick, Sr. Sechrist 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 3855 Kings Arms Lane York, Pa. 17402 Edward G. Ness, Jr./ Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) White Rose Crematorium 8−29, 2008 York, Pa. 21. Signature of Funeral Service License 22. Name and Address of Facility 1050 York Road Ruck Towson Funeral Home Towson, MD 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ardiac Valvular year /Medical Due to (or as a consequence of): Examiner Myocardial week Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division or Vital Records, P.O. Box 68760, attending physician Physician/Medical use as the IF FEMALE: 23c. If yes, outcome pf pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has performed 1☐ Yes 2 **□** No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 npatient 2 ER/Outpatient 3 DOA Certification: To 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified

State Registrar 6 vegne

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2008

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Registrar's Signature

MENAKEL

31. Date filed (Month, Day, Year) SEP 0 2

0060292

August 27,

2003

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** N/A **Baltimore City** The Johns Hopkins Hospital Date of Birth (Month, Day, Year) 5/10/196 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F PA 43 204-40-2498 /10/1965 Director Usual Residence of Decedent 10d. Inside City Limits death with the Maryland 10c. City, Town or Location show 10a. State 10b. County notified at ty Yes 2 □ No Director DC N/A WASHINGTON 28a-f 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number ь ě 20010 USA 1812 INGLESIDE TERRACE NW, APT. 23a must h Funeral 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after of thealth and Mental Hygiene. nt: If item 27 is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) the Medical (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Secondary (0-12) PHYSICIAN MEDICINE 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be COLEMAN NADLER MIRIAM KRASNOW ည 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) MIRIAM NADLER / MOTHER 403 PEMBROKE ROAD BALA CYNWYD, PA 19004 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition permit. Pages 1
Department of H
important: If ite
any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 X Removal from State MT. SHARON CEMETERY 8/29/2008 SPRINGFIELD, PA 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 ale Approximate Interval Between Onset and Death or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest 23a, Part 1. Enter the diseas shock, or heart failure. List only one cause on each line. Gliobla Immediate Cause (Final MONTH **Physician** disease or condition /Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence or, Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE: ves, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Live birth Month Day Year in the past 12 months? for Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Completed by 1 TYes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ate has page 2 2 🗌 No 1 ☐ Yes 2 X No Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) director, Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospital: 1 ☐ Yes ≥ No 1 Unpatient 2 ER/Outpatient 3 DOA မ this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification: I Director: After to in by the funer 1 Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident after death 3 Suicide Could not be determined 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide hin 24 hours a the Funeral D mpletely filled filled 17 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

within 2 To the I

State Registrar

MINOFF

32. Redistrar's Signature

son who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

29b. Signature and little of certifi

30. Name and address of per

zara

29c. License number

29d. Date signed (Month, Day, Year)

600 North Wolfe St, Baltimore, MD, 21287

State Registrar

31. Date filed (Month, Day, Year)

Granton

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)



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Herows me

			1 - State of Maryland / Dep	artment of Health and Nertificate of Death	, ,	ene g. No. 2008	27999							
	Physici	an	1. Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death							
	/Medic	al	ANN LOUISE PEACE	Tu on a	August :		4:40A M							
	Examin	er	4a. Facility Name (If not institution, give street and number) Pickersgill	4b. City, Town, or Location of Death TOWSON	1	4c. County of Death Baltimor								
, in the second	Funeral Director		5. Social Security Number $\begin{array}{c cccc} 6. \text{ Sex} & 7. \text{ Age (In yrs. last birthday} \\ 216-12-0706 & {}^{1}\square\text{ M} & {}^{3}\!$		8. Date of Birth (Month, Day, March 2,		place (State or Foreign							
	land ow t		Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits							
	a-f sho	tor	Maryland Baltimore Towson				1 □Yes 2 □No							
	vith the	Dire	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cou								
	eath w ns 23a must I	Funeral Director	615 Chestnut Avenue 11. Marital Status 12. Was Decedent Ever in U.S. 13.	Was Decedent of Hispania Origin? (Sr	posific Vos or No	USA 14. Race - American Indian.								
036	be filed within 72 hours after death with the Maryland ital Hyglene. ed other than "natural", or Items 23a or 28a-f show event, the Medical Examiner must be notified at	by	Armed Forces? 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	Was Decedent of Hispanic Origin? (Spilf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 ☑ No Specify:	o Rican, etc.)	Black, White, etc. Specify: White								
5-0036	72 hoi 'naturi dical E	Completed	15. Decedent's Education 16a. Deci (Specify only highest grade completed) (Giv	edent's Usual Occupation e kind of work done during most of work	kina I	6b. Kind of Business/In	dustry							
127	within ene. than "	Jdm	Elementary/Secondary (0-12) College (1-4or 5+)	e kind of work done during most of worl DO NOT use retired) Naker	9	0								
2	il Hygi other rent, th	Be Co	17. Father's Name (First, Middle, Last)		ne (First, Middle, M	Own Home daiden Surname)								
yland	buld be Mental arked o	To B	John Benjamin Thomas		Lydia Boucher									
Mar	d 2 sho th and 7 is m traum			ing Address <i>(Street and Number or Ru</i> N Calvert Street B										
ē,	s 1 an if Heal item 2 other		20a. Method of Disposition 20b. Place of Disp			Oc. Location - City or To								
<u>=</u>	Page ment o ant: If ury or		I A Ibunal 21 ICremation 31 Bernoval from State 1	ge Cemetery 9/4/	08 F	Pikesville,	Maryland							
Baltimore,	permit. Pages 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any Injury or other traumatic evonce.		21. Signature of Funeral Service Licenses (CMURL)	2. Name and Address of Facil Mitc 6500 York Roa	hell-Wied	defeld Fune	ral Home In							
	THE I	,	23a. Part 1. Enter the disease. If complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximation of the proving shock or heart failure. List only one care so on each line.											
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	ve		Onset and Death								
	Examiner		Due to (or as a consequence of):	castro-intesse	tind c	MCCR	months							
	20. #	iner	Secural fally let con the case of injury that initiated events Secural fally let con the case of injury that initiated events Due to (or as a consequence of):)	-									
	and and II-trans	Examiner	Cause (Disease or Injury that initiated events resulting in death) Last c											
8/60	ficate be executed Physician and s the burial-transit	dical E	d											
0	rtificat ng phy	Medi	IF FEMALE:											
C. BOX	To the Hospital or Attending Physician: The av requires that the death certification within 24 hours after death. To the Funeral Director: After this certificate his been signed by the attending is completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 ments? 1□Live birth 2 □ Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of delive Month	ery Day Year							
7.	s that 1 ned by e detar		Part II. Other significant conditions contributing to death but not resulting in the	inderlying cause given in Part I.	23e. Did toba	acco use contribute to t	he cause of death?							
oras,	equire en sig ould b	ed b	irm beficiency Anemin, Atial	fibrillation	1 ☐ Yes	s 2 No 3 Prol	bably 4 □Unknown							
	The av rate has be	Completed by	ostob porosis		24a. Was an autopsy perform	prior to co	opsy findings available impletion of cause of							
VIII	ician: certific ector,	Be	25. Was case referred to medical examiner? Hospital:	Other	th (Check only one,		Heristek							
Ö	y Physer this eral dii	٦. T	27. Manner of Death 28a. Date of Injury 28b. Time of	AL Nursing Ho	ome 5 Resident	nce 6 Other (Special	1) Living							
5	ath. r: Afte	atior	1 ☑Natural 5 □ Pending (Month, Ďay Year) Injury 2 □ Accident investigation	Work? M 1 ☐ Yes 2 ☐ No		,	t Aciti							
JIVISION	or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town,	eet and Number or Rura State)	al Route Number,							
_	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	Medical Ce	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, dea 2 ☐ Medical Examiner: On the basis of examination and/or i and manner stated.	th occurred at the time, date and place, ovestigation, in my opinion, death occur	, and due to the cau	use(s) and manner as s te and place, and due t	stated. o the cause(s)							
	To the within To the Comply	Me	29b. Signature and title of certifier	29c. License number	299	d. Date signed (Month,	Day, Year)							
•			If forthy they is	W25205	4	2908/28	, 200f							
	10		30. Name and address of person who completed cause of death (Item 23a) (Type	Printy Charles.	Balto.	AND 212	:05							
	Sta Registra		31. Date filed (Month, Day, Year) / 32. Registrar's Signature	di)										
			OLI OC COOL MANAGEMENT NO.											

DHMH 17 Rev 1/2001

08-06646					
Brenda	Queen				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

enda Queen	1-	State of Maryland / Department of Health and Mental For State Certificate of Death	Hygiene Reg.	200	08 2800			
Physician/		egistrar Decedent's Name (First_Middle Last)	2. Date of Death		3. Time of Death 1929 hrs			
ledical Examine		Brenda Queer a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of De	Month D August 30, 2	4c. County of Death				
		Johns Hopkins Hospital Baltimore		NI	4			
Funeral Director	0	215-82-4750 1 M 2 F F Yrs.	Min d	MM/DD/YYYY) 9. Birt Foreig Con				
d how any	1	Job. County Maryland NA Bottom Bottom Bottom	re		10d. Inside City Limits 1 Yes 2 No			
th the Maryland 23a or 28a-f show notified at once.		10e. Street and Number 21229		. Citizen of What Cour USA	}			
er death wi		11. Marital Status 1 Never Married		14. Race - Ameri White, etc. Specify: Bla	ican Indian, Black,			
5 72 hours aft an "natural" cal Examine	S	15. Decedent's Education (Specify only highest grade completed) Flementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+)	e retired)	16b. Kind of Business/	Industry C Maryland			
21215-0036 Motal Hygiene. marked other than c event, the Medical	17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)							
nore, MD 2121. ages I and 2 should be fif and 1 should be figured. It if item 27 is marked other traumatic event,	0 1	19a. Informant's Name/Relationship Type, Print) 19b. Mailing Address (Street and Number 3454 W. Cater	Ave. E	er, City or Town, State Saltimore 20c. Location - City of	Maryland			
		20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, crematory or other place) Trinty Cemetery	9/6/08		e, Maryland			
	1	21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3512 Frederic 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card	KAVE. B	attimore.	Ma Mard Ap oximate interval			
Physician / dical kaminer		failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): Due to (or as a consequence of):						
		Sequentially list conditions, if any, leading to immediate Cause. Enter Underlying Cause						
	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):							
be exessician	X UNPENDED AMENDED 3a,PII,27,perME, g883 9/12/08 TT							
Box 6876(e death certificate the attending phy ed for use as the b	Physician/M							
P.O. B s that the degree by the edetached								
24a. Was an autopsy prior to completion of co death?								
tal Rec	Be C	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA Other 1		Residence 6 Oth	let.			
on of Virenting Physicath. or: After this the funeral directions.	₽ -	1 ✓ Yes 2 No Thingatent 2 ✓ Errodupatent 5 28c. Injury at Work? 1 ☒ Natural 5 Pending 28a. Date of Injury (Month, Day, Year) 1 ☐ Yes 2 No 1	28d. Describe h	now injury occurred				
O sign of the street of the st								
Divis	To a continue the continue that the time, date and place, and due to the cause(s) and mainter as stated. Conclude only and mainter as stated. Conclude only and mainter as stated. Conclude only and mainter as stated. Conclude only and mainter as stated. Conclude only and mainter as stated. Conclude only and mainter as stated.							
	ĕ	29b. Signature and title of certifier 29c. License number O.C.M.E.		29d. Date signed (M August 31, 200				
.6	İ	30. Name and address of person who completed cause of death (Item 23a) Tasha Greenberg MD. Assistant Medical Examiner 111 Penn Street, Baltimore	e, MD 21201					
State 31. Date filed (Month, Day, Year) Registrar S.F.P. 0. 2. 2008								
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